SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: eApp (03/09)	SERFF Tr Num: MGCC-126107568	State: Arkansas
TOI: H15I Individual Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed-Disapproved	State Tr Num: 42368
Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical Expense	Co Tr Num: CH/MG-25098-EAPP (03/09) AR (FOR CLICO)	State Status: Disapproved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Chalon Ybarra, Courtney Sharp, Jaime Butler	Disposition Date: 09/30/2009
	Date Submitted: 05/08/2009	Disposition Status: Disapproved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: eApplication (CH/MG Combo (03/09))	Status of Filing in Domicile:
Project Number: eApp (03/09)	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 09/30/2009	Explanation for Other Group Market Type:
	State Status Changed: 09/30/2009
Deemer Date:	Created By: Chalon Ybarra
Submitted By: Chalon Ybarra	Corresponding Filing Tracking Number:

Filing Description:

Electronic Application Form CH/MG-25098-eAPP (03/09) AR

Company and Contact

Filing Contact Information

Chalon Ybarra, Compliance Analyst II	chalon.ybarra@healthmarkets.com
9151 Boulevard 26	817-255-5487 [Phone]

SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

North Richland Hills, TX 76180 817-255-8153 [FAX]

Filing Company Information

The Chesapeake Life Insurance Company	CoCode: 61832	State of Domicile: Oklahoma
9151 Boulevard 26	Group Code: 264	Company Type: Health
North Richland Hills, TX 76180	Group Name:	State ID Number:
(817) 255-3100 ext. [Phone]	FEIN Number: 52-0676509	

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	$20.00 per form x 1 form = $20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	$20.00	05/08/2009	27744987

SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	09/30/2009	09/30/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/15/2009	05/15/2009			

SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

Disposition

Disposition Date: 09/30/2009
Implementation Date:
Status: Disapproved
Comment:

Since we have not received a reply to my objection letter of 5/15/09, the filing is being disapproved.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Disapproved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	Health - Actuarial Justification	Disapproved	Yes
Supporting Document	Outline of Coverage	Disapproved	Yes
Supporting Document	Cover Letter	Disapproved	Yes
Supporting Document	Variability Statement	Disapproved	Yes
Form	Application	Disapproved	Yes

SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/15/2009
Submitted Date	05/15/2009
Respond By Date	

Dear Chalon Ybarra,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application, CH/MG-25098-eAPP (03/09) AR (Form)

Comment: The underwriting company should be on the first page of the application and be more prominent than "HealthMarkets".

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

Form Schedule

Lead Form Number: CH/MG-25098-eAPP (03/09) AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Disapproved 09/30/2009	CH/MG-25098-eAPP (03/09) AR	Application/ Enrollment Form	Application	Initial		50.000	CHMG-25098-eApp_0309_AR.pdf

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PRIMARY APPLICANT: [John Doe]
[PRODUCER NAME: [Bobby Greatagent] **]**

APPLICATION SUMMARY

APPLICANT INFORMATION

Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.

Is the Primary Applicant an adult dependent? ❍ Yes ● No
Is this a child-only application? ❍ Yes ● No

[APPLICANT DEMOGRAPHICS]

First Name: [John] **Middle Initial:** [C]
Last Name: [Doe] **Suffix:**
Physical (no PO Box) Address: [1234 Anywhere St]
Apt or Suite Number: [Apt. 123]
City: [Ft. Worth]
State: [Texas] **ZIP Code:** [12345-[6789]]
County: [Tarrant] *{this will auto-generate based on Physical Address Zip Code and State}*

Home Phone Number: [123-456-7890] **Cell Phone Number:** [456-123-7899]
Daytime Phone Number: [098-765-4321] **Fax Phone Number:** [987-654-4321]
Preferred Contact Number: [Daytime]
Best Time to Call: [AM] **Email:** [john.doe@email.com]

Marital Status: ● Married ❍ Single [❍ Common Law *{this will only be an option IF the state recognizes this as a legal marriage/unity}*] [❍ Domestic Partnership *{this will only be an option IF the state recognizes this as a legal marriage/unity}*]
SSN: [123-45-6789] **Gender:** ● Male ❍ Female
Date of Birth: [08/04/1976] **Age:** [32] *{auto-calculation based on "Date of Birth" and today's date}*
Birthplace: [state] **Height:** [6 feet 2 inches]
Other: [i.e. Russia] **Weight:** [220]

Occupation/Duties: [none]
Is Applicant a U.S. Citizen? ❍ Yes ❍ No

[Mailing Address]

Mailing Address: [1234 Anywhere St]
Apt or Suite Number: [Apt. 123]
City: [Ft. Worth]
State: [Texas] **ZIP Code:** [12345-[6789]]

[Coverage Information]

Request for Special Effective Date: [01/15/2009]

[Additional Detail

{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans}

1. Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father? ❍ Yes ● No

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2. Is the Applicant, spouse or any dependent child (even if not proposed for insurance) being tested for or receiving treatment for infertility/fertility, in the process of adoption or surrogacy (with anyone, whether or not this person is applying for coverage? ❍ Yes ● No

3. Has the Applicant used tobacco products in the past twelve (12) months? ❍ Yes ● No

4. Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License? ❍ Yes ● No

5. Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? ❍ Yes ● No

6. Has the Applicant ever been convicted or prosecuted for any criminal activity? ❍ Yes ● No **]**

[Income and Disability Detail

{The following questions are only applicable if Primary or Spouse Applicant(s) chose the "Income Protection Plan" (Accident-Only Disability Income Insurance Certificate) (Form # [25916-C]) or the "Income Protection Plus Plan" (Disability Income Insurance Certificate) (Form # [25915-C]); not applicable for Dependent Applicant(s).}

1. Does the Applicant currently have Disability Income Insurance (either through your employer or as an individual policy)? ❍ Yes ● No **]**

FAMILY MEMBERS

[Family Member 1]

First Name:	[Jane]	**Middle Initial:**	[A]
Last Name:	[Doe]	**Suffix:**	
SSN:	[123-45-6789]		
Date of Birth:	[08/19/1978]	**Age:**	[30] *{auto-calculation based on "Date of Birth" and today's date}*
Relationship	[spouse]	**Gender:**	❍ Male ● Female
Height:	[5 feet 4 inches]	**Weight:**	[130]
Birthplace:	[state]	**Other:**	[i.e. Russia]

Occupation/Duties: [working woman]

Is Applicant a U.S. Citizen? ● Yes ❍ No

Same address as Primary Applicant? ● Yes ❍ No

[Additional Detail

{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans}

1. Has the Applicant used tobacco products in the past twelve (12) months? ❍ Yes ● No

2. Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License? ❍ Yes ● No

3. Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? ❍ Yes ● No

4. Has the Applicant ever been convicted or prosecuted for any criminal activity? ❍ Yes ● No **]**

[Income and Disability Detail

{The following questions are only applicable if Primary or Spouse Applicant(s) chose the "Income Protection Plan" (Accident-Only Disability Income Insurance Certificate) (Form # [25916-C]) or the "Income Protection Plus Plan" (Disability Income Insurance Certificate) (Form # [25915-C]); not applicable for Dependent Applicant(s).}

1. Does the Applicant currently have Disability Income Insurance (either through your employer or as an individual

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policy)? ❍ Yes ● No **]**

[Family Member 2]

First Name: [Baby] **Middle Initial:** [B]
Last Name: [Doe] **Suffix:**
SSN: [123-45-6789]
Date of Birth: [01/17/2006] **Age:** [2] *{auto-calculation based on "Date of Birth" and today's date}*
Relationship [dependent] **Gender:** ● Male ❍ Female
Height: [3 feet 1 inches] **Weight:** [42]
Birthplace: [TX] **Other:** [i.e. Russia]
Occupation/Duties: [none]
Is Applicant a U.S. Citizen? ● Yes ❍ No
Same address as Primary Applicant? ● Yes ❍ No
Is this an adoption/guardianship? ❍ Yes ● No
Is Dependent Applicant between the ages of 19 and 24? ❍ Yes ❍ No
Is this Applicant a full-time student? ● Yes ❍ No
[[If "Yes",] Name of School: [Great University] **]**
Explain: [details]
Is this Applicant incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on the Primary Applicant for support and maintenance? ❍ Yes ● No

[Additional Detail
{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans}

1. Has the Applicant used tobacco products in the past twelve (12) months? ❍ Yes ● No

2. Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License? ❍ Yes ● No

3. Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? ❍ Yes ● No

4. Has the Applicant ever been convicted or prosecuted for any criminal activity? ❍ Yes ● No **]**

CHOICE OF COVERAGE
The following [Certificates] [Policies] are underwritten by The Chesapeake Life Insurance Company:

[Plan Name]	[Applicant(s)]	[Description]	[Monthly Premium]
[Chesapeake ESSENTIAL Fit (Catastrophic Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26210 PPO-IP (03/09) AR] (EFIL)]	[John Doe]	**[Calendar Year Deductible:** [$2,500 per Person, In-Network / $5,000 per Person, Out-of-Network $5,000 per Family, In-Network / $10,000 per Family, Out-of-Network] **]** **Coinsurance:** [70% In-Network / 50% Out-of-Network] **Calendar Year / Lifetime Maximum:** [$1,000,000 / $2,000,000] **[Coinsurance Maximum (per Calendar Year):** [$2,500 per Person, In-Network / $5,000 per	[$$$$.$$] [Incl.]

		Person, Out-of-Network $5,000 per Family, In-Network / $10,000 per Family, Out-of-Network] **]** **Option of Network:** [023-Private Health Care Systems (PHCS)]	
[Chesapeake BASIC Fit (Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26220 PPO-IP (03/09) AR] (BFIL)]	[Jane Doe] [Baby Doe]	**[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible:** [$2,000 per Person, In-Network / $4,000 per Person, Out-of-Network] **]** **Coinsurance:** [70% In-Network / 50% Out-of-Network] **Lifetime Maximum:** [$500,000] **Hospital Inpatient & Miscellaneous / Inpatient Surgeon Maximum Benefit Amount:** [$7,500 / $3,000] **Outpatient Surgery Facility / Outpatient Surgeon Maximum Benefit Amount:** [$3,750 / $1,000] **Option of Network:** [023-Private Health Care Systems (PHCS)]	[$$$$.$$] [Incl.]
[Physician Office Services Benefit Rider (Form # CH-26223-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	**Copayment (per Person, per Visit):** [$25 In-Network / $50 Out-of-Network] **Visit Limitation (per Person, per Calendar Year):** [2]	[$$$$.$$] [Incl.]
[Outpatient Accident Expense Benefit Rider (Form # CH-26221-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	**Copayment (In-Network and Out-of-Network):** [$50] **Maximum Benefit Amount (per Person, per Calendar Year):** [$500]	[$$$$.$$] [Incl.]
[Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form # CH-26224-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	**[Copayment][Facility Fee] (per Person, per Visit):** [$150 In-Network / $300 Out-of-Network] **[Combined Visit Limitation (per Person, per Calendar Year):** [15] **]**	[$$$$.$$] [Incl.]

[Continued Care Benefit Rider (Form # CH-26225-IR (03/09) AR)]	[John Doe] [Jane Doe] [Baby Doe]		[$$$$.$$] [Incl.]
[Outpatient Diagnostic Services Benefit Rider (Form # CH-26226-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	**[[Copayment][Facility Fee] (per Person, per Visit):** [$250 In-Network / $500 Out-of-Network] **]** **[Maximum Benefit Amount (per Person, per Day):** [$500] **]** **[Maximum Benefit Amount (per Person, per Calendar Year):** [$2,500] **]**	[$$$$.$$] [Incl.]
[Covered Services Extension Rider (Form # CH-26228-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]		[$$$$.$$] [Incl.]
[Rate Guarantee Rider (Form # CH-26205-IR (08/08))]	[John Doe] [Jane Doe] [Baby Doe]	**Guarantee Level:** [24] months	[$$$$.$$] [Incl.]
[Pregnancy/Childbirth Benefit Rider (Form # [CH-26213-IR (03/09) AR])]	[John Doe] [Jane Doe] [Baby Doe]	**Maximum Benefit Amount (per pregnancy/childbirth):** [$1,000]	[$$$$.$$] [Incl.]
[Prescription Drug Expense Rider (Form # [(CH-26214-IR (03/09) AR)]]	[John Doe]	**Maximum Benefit (per person, Calendar Year):** [$1,500] **Generic / Brand Drug Deductible (per Person, per Calendar Year):** **[** [$0 / $250] **]** **Retail:** Generic Preferred Drugs, [30] day supply: [100%] less [$5] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [$15] copayment Brand Preferred Drugs, [30] day supply discount: [50%] Brand Non-Preferred Drugs, [30] day supply discount: [25%] **Mail-Order:** Generic Preferred Drugs, [90] day supply: [100%] less [$15] copayment Generic Non-Preferred Drugs, [90] day supply: [100%] less [$45] copayment Brand Preferred Drugs, [90] day supply discount: [50%]	[$$$$.$$] [Incl.]

		Brand Non-Preferred Drugs, [90] day supply discount: [25%]	
[Prescription Drug Expense Rider (Form # [(CH-26222-IR (03/09) AR)]]	[Jane Doe] [Baby Doe]	**Maximum Benefit (per Person, per Calendar Year):** [$500] **Deductible (per Person, per Calendar Year):** [$250] **Retail:** Generic Preferred Drugs, [30] day supply: [100%] less [$5] [$10] [$15] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [$20] [$25] [$30] copayment Brand Name Drugs, [30] day supply discount: [25%] **Mail-Order:** Generic Preferred Drugs, [90] day supply: [100%] less [$10] [$20] [$30] copayment Generic Non-Preferred Drugs, [90] day supply: [100%] less [$40] [$50] [$60] copayment Brand Name Drugs, [90] day supply discount: [25%]	[$$$$.$$] [Incl.]

The following Certificates/Policies are underwritten by The MEGA Life and Health Insurance Company:

[MEGA Vision Plan (Vision Insurance Policy) (Form # [(26023-IP (5/07) AR)]) (VSIN)]	[John Doe] [Jane Doe] [Baby Doe]	NETWORK: Deductible: [$0] Comprehensive Eye Exam: [100%] Corrective Spectacle Lenses: [100%] Corrective Contact Lenses (Non-Disposable or Disposable): [$40] Corrective Contact Lenses (Therapeutic): [100%] Frames: [Not Covered] Contact Lens Fitting: [Not Covered] Follow-Up Visits: [Not Covered] NON-NETWORK: Deductible: [$0] Comprehensive Eye Exam: [$30] Corrective Spectacle Lenses: [75%] Corrective Contact Lenses (Non-Disposable or Disposable): [$30] Corrective Contact Lenses (Therapeutic): [75%] Frames: [Not Covered] Contact Lens Fitting: [Not Covered] Follow-Up Visits: [Not Covered]	[$$$$.$$] [Incl.]
[MEGA Bronze (Dental Insurance Policy) Form # [26099-IP (1/08)]	[John Doe] [Jane Doe]	[BRONZE (Option A-Diagnostic & Preventive): Deductible: [$0]]	[$$$$.$$] [Incl.]

(DTLB)]	[Baby Doe]		
[MEGA CancerWise (Cancer Benefit Policy) (Form # [(26055-IP (5/07) AR)]) (ECAN)]	[John Doe] [Jane Doe] [Baby Doe]	First Diagnosis Cancer Benefit Amount (per person, per lifetime): [$10,000]	[$$$$.$$] [Incl.]
[Income Protection (Accident-Only Disability Income Insurance Certificate) (Form # [25916-C]) (DIGP)]	[John Doe]	Monthly Indemnity Benefit (per disabled person): [$500] Elimination Period (per disabled person): [30] days	[$$$$.$$] [Incl.]
[Income Protection Plus (Disability Income Insurance Certificate) (Form # [25915-C]) (DSGP)]	[Jane Doe]	Monthly Indemnity Benefit (per disabled person): [$500] [White Collar: Yes]	[$$$$.$$] [Incl.]
[Waiver of Premium Benefit Rider (Form # [25917])]	[John Doe] [Jane Doe]		[$$$$.$$] [Incl.]
[Endorsement Return of Premium Benefit (Form # [25918])]	[John Doe] [Jane Doe]		[$$$$.$$] [Incl.]
[Critical Care Plus (Specified Disease/Condition Or Major Organ Transplant Certificate) (Form # [25936-C]) (CI01)]	[John Doe] [Jane Doe] [Baby Doe]	First Occurrence Benefit Amount (per person, per lifetime): [$10,000]	[$$$$.$$] [Incl.]
[MEGA Accident Advantage (Accidental Injury Only Insurance Certificate) (Form # [26038-C]) (ASLG)]	[John Doe]	Accidental Injury Benefit Amount, per person, per year: [$5,000]	[$$$$.$$] [Incl.]
[Accident Expense Insurance Plan (Accident Catastrophic Expense Plan Certificate of Insurance) (Form # [25314]) (IA08)]	[Jane Doe] [Baby Doe]	Deductible, per person, per occurrence: [$2,400] Maximum Benefit, per person, per occurrence: [$6,000] Coinsurance: [50%]	[$$$$.$$] [Incl.]
[Accident Expense Benefit Rider (Form # [25096])]	[John Doe] [Jane Doe] [Baby Doe]	Deductible, per injury: [$0] Maximum Benefit, per injury [$600]	[$$$$.$$] [Incl.]
[Direct Benefit (Hospital Confinement Indemnity Certificate) (Form # [25874-C]) (DB01)]	[John Doe] [Jane Doe] [Baby Doe]	Daily Benefit Amount (per person): [$100]	[$$$$.$$] [Incl.]

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[023-Private Health Care Systems (PHCS)]		[$$$$.$$] [Incl.]
[Certificate][Policy] Fee		[$$$.$$] [Incl.]
	Total Estimated Recurring Payment:	[$$$$.00]
	Total Initial Payment:	[$$$$.00]

The estimated premium is provided prior to review by the Underwriting Department and may change after underwriting review. You will be notified if there is any change to the estimated recurring payment as a result of underwriting review.

{The following section is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans}

PHYSICIAN DETAILS (Name of current Physician and any other Physician or specialist seen in the past 12 months)

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Primary Applicant: [John Doe]
Physician/Specialist Name: [James Brown, MD]
Phone Number: [123-456-7890]
Address Line 1: [1234 Anywhere Street]
Address Line 2: [Suite ABC]
City: [My Town]
State: [My State] **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]
Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Spouse Applicant: [Jane Doe]
Physician/Specialist Name: [James Brown, MD]
Phone Number: [123-456-7890]
Address Line 1: [1234 Anywhere Street]
Address Line 2: [Suite ABC]
City: [My Town]
State: [My State] **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]
Recommendation(s)? [recommendations]

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APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Dependent Applicant: [Baby Doe]
Physician/Specialist Name: [Baby Doctor, MD]
Phone Number: [123-456-7890]
Address Line 1: [1234 Anywhere Street]
Address Line 2: [Suite ABC]
City: [My Town]
State: [My State] **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]
Recommendation(s)? [recommendations]

{The following section is only applicable if "10 Year Term Life Plan" (Renewable Term Life Insurance Plan Certificate, form 25919-IP (1/09) TX is chosen. This section will replicate for every Applicant that applied for the Renewable Term Life Insurance Plan Certificate.}

BENEFICIARY INFORMATION
[John Doe] Beneficiary Information Details

BENEFICIARY 1

First Name: [Jane] **Middle Initial:** [A]
Last Name: [Doe] **Suffix:**
Beneficiary Relationship: [Wife] **Percentage:** [XXX%]
Other:
City: [Fabulous]
State: [State]
Zip: [12345-9876]

BENEFICIARY 2

First Name: [Baby] **Middle Initial:** [B]
Last Name: [Doe] **Suffix:**
Beneficiary Relationship: [Son] **Percentage:** [XXX%]
Other:
City: [Fabulous]
State: [State]
Zip: [12345-9876]

PRIOR COVERAGE

{The following question is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans}

MEDICARE/MEDICAID

Is any Applicant eligible for or currently covered under Medicare or Medicaid? ❍ Yes ● No

[If "Yes", who?	**Reason**	
❍ [John Doe]	[Financial]	[Medical]
❍ [Jane Doe]	[Financial]	[Medical]
❍ [Baby Doe]	[Financial]	[Medical]

CURRENT HEALTH INSURANCE

During the past two years, has any person to be insured had insurance declined, postponed, had a waiver applied, or charged additional premium for life, disability or health insurance or had such insurance rescinded? ❍ Yes ● No

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Does any Applicant currently have health insurance or has any Applicant had health insurance within the past 12 months? ❍ Yes ● No
[If "Yes", has coverage been in force within the past 60 days? ❍ Yes ❍ No] [If "No", date of cancellation: [MM/YYYY]]

CURRENT LIFE INSURANCE
Does any Applicant currently have life insurance or annuities? ❍ Yes ● No

Will the insurance applied for replace or otherwise reduce in value any life insurance or annuities now in force?
❍ Yes ● No

{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans}

[MEDICAL QUESTIONS

Have you or any Applicant **EVER** had symptoms, been diagnosed, received medical advice or been treated for:

1. Hazardous Activities or Sports - does Any Applicant to be insured engage in any hazardous sport or activity? ❍ Yes ● No
[If "Yes", is it professionally or for recreation? ❍ Professionally ❍ Recreationally]

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

2. Heart or Cardiovascular Conditions/Disorders including but not limited to - Heart attack, stroke, myocardial infarction, hypertension (high blood pressure), angina pectoris, transient ischemia attack (TIA), coronary artery disease, any form of heart surgery, coronary artery surgery, heart related arteriogram, angioplasty or pacemaker, or disease or disorder of the heart or circulatory system? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

3. Endocrine Disorders including but not limited to – Diabetes (high blood sugar), hypoglycemia (low blood sugar), goiter, thyroid disorder, or obesity? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

4. Blood Disorders including but not limited to - Blood or spleen disorder, including anemia, leukemia, high cholesterol, or hyperlipidemia? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

5. Gynecological Disorders including but not limited to – male or female reproductive organ disorder or disease, including breast disorder or augmentation? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

6. Cancer / Tumor or any benign or malignant growths, including but not limited to - Cancer, cyst, tumor, or neoplasm? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe]

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❍ [Baby Doe]

7. Respiratory Disorders including but not limited to - Respiratory disorder, including asthma, bronchitis, COPD (Chronic Obstructive Pulmonary Disease), emphysema, lung disease, sleep apnea, or breathing problems? ❍ Yes ● ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

8. Urinary Tract Disorders including but not limited to - Kidney, bladder, urinary tract, stones, or prostate disorders? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

9. Digestive Tract Disorders including but not limited to – GERD (gastroesophageal reflux disease), Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis, hepatitis, or pancreatitis? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

10. Colon Disorders including but not limited to - Hernia, chronic diarrhea, bloody stool, hemorrhoids, polyps, or rectal disorders? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

11. Eye, ear, nose, or throat disorders - Eye, ear, nose, or throat disorders? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

12. Skin Disorders including but not limited to - Skin disorders, burns, lacerations, dermatitis, boils, chronic rashes, or melanoma? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

13. Musculoskeletal Disorders including but not limited to - Back, shoulder, hands or feet, spine, arm or leg disorder, or arthritis, gout, bursitis, or neuritis? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

14. Complications of Pregnancy including but not limited to - Cesarean section? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

15. Brain Disorders including but not limited to - Epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury, or chronic headaches? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

16. Mental and Nervous Disorders including but not limited to - Depression, anxiety, alcoholism, alcohol abuse, drug abuse, or drug addiction? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe]

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❍ [Baby Doe]

17. Connective Tissue Disorders including but not limited to - Hodgkin's or Non-Hodgkin's Lymphoma, cystic fibrosis, collagen disease, or connective tissue disease? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

18. Abnormal Test Results - Any abnormal results of a cancer test such as a PAP Smear, mammogram, CEA (carcinoembryonic antigen), PSA (prostate specific antigen), or chest X-ray? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

19. Symptoms of other Medical Conditions - Abnormal bleeding, swollen or enlarged prostate, or night sweats? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

20. Muscular Disorders - Any neurological disease or disorder that would include numbness of any extremity, any muscular disease or disorder, or loss of use of any limbs? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

21. AIDS / HIV - Have you or any Applicant(s) ever been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an AIDS-related test? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

22a. Recent Medical Treatment - WITHIN THE LAST 5 YEARS, have you had any other medical or surgical advice, hospitalizations, treatment, operations, or testing? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

22b. Recent Medical Treatment – WITHIN THE LAST 3 YEARS, have you or any Applicant taken, been advised to take, or been prescribed any medication(s), including any which were not filled? ❍ Yes ● No

[If "Yes", what condition(s) is the prescribed medication for?] [conditions]

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

22c. Recent Medical Treatment – Have you or any Applicant(s) been advised to have additional testing, lab work, surgical or medical treatment, or had such that has not yet been completed? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]]

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{The following questions are only applicable if Applicant(s) chose the "Critical Care/Plus Plan" (Specified Disease/Condition Or Major Organ Transplant Certificate) (Form # [25936-C])}

23. Family History - Have either of your parents, brothers, or sisters been diagnosed or been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer disease, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or diabetes? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

24. Transplant - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke, disease of the heart or blood vessels, renal failure, multiple sclerosis, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or Alzheimer disease? ❍ Yes ● No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

PAYMENT INFORMATION

[CREDIT/DEBIT CARD INITIAL PAYMENT]

1st Payment:	[$$$.00]
Credit Card Type:	[❍ VISA ❍ MasterCard]
Name of Cardholder as it appears on the card:	[John Doe]
Relationship of Payor to Primary Applicant:	[self]
[Reason for Payor Being Different than Applicant:	[reason] **]**
Type of Card:	[❍ Credit ❍ Debit]
Account Type:	[Personal]
Credit Card Number:	[5525-XXXX-XXXX-XX54]
Expiration Date:	[01/10]
Cardholder's Billing Address Line 1:	[address]
Cardholder's Billing Address Line 2:	
City:	[city]
State:	[TX]
Zip:	[zip code]
Cardholder's Phone Number:	[phone number]

[ONGOING PAYMENTS]

Ongoing Payments:	[● Checking Account Electronic Fund Transfer (EFT) ❍ Savings Account Electronic Fund Transfer (EFT) ❍ Bill Me]
Payment Mode:	[● Monthly ❍ Quarterly ❍ Annually]
Bank Routing Number:	[xxxxx9485]
Bank Account Number:	[xxxxx0089]
Confirm Bank Routing Number:	[xxxxx9485]
Confirm Bank Account Number:	[xxxxx0089]
Account Type:	[Personal]
Name of Financial Institution:	[My Favorite Bank]

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Primary Name on Bank Account:	[John C Doe]
Relationship of Payor to Primary Applicant:	[relationship]
[Reason for Payor Being Different than Applicant:	[reason] **]**

HEALTH APPLICATION TERMS AND CONDITIONS

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the certificate/policy is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

ELECTRONIC SIGNATURE – [John Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

☒ By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

ELECTRONIC SIGNATURE – [Jane Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

☒ By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

FOR HOME OFFICE USE ONLY

Special Request(s):	[office use only text] *{only agent allowed to fill in text here}*
[Association] Membership:	[NASE Premiere] *{system-generated}*
[Association] Membership Number:	[0123456789] *{system-generated}*
[Association Membership] Paid-to Date:	[09/15/2008] *{system-generated}*
[Association Membership] Effective Date:	[06/15/2008] *{system-generated}*
Lead ID:	[1234-ABC]
Market Type:	[Association Group (I)]

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ELECTRONIC SIGNATURE – [Bobby Greatagent]

Producer ID: [123456789]

Do you have any knowledge or reason to believe that the proposed Insured(s) is intending to replace or otherwise reduce in value any existing life insurance or annuities? ❍ Yes ❍ No

By checking the box and entering my name below, I am indicating my agreement with the indicated statement and my intent to electronically sign this application.

☐ I certify that each question on this application was asked by me of the Applicant(s), and I have accurately recorded all answers given by the Applicant(s).

OR

☐ I certify to the best of my knowledge and belief the Applicant(s) has/have personally recorded the answers to each question on this application.

Please type your name in the spaces below to electronically sign your application.

First Name: [Bobby] MI: [B] Last Name: [Greatagent] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [Bobby] MI: [B] Last Name: [Greatagent] Suffix:

END OF APPLICATION FOR INSURANCE

SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Disapproved	09/30/2009

Comments:

Attachments:

AR.CLICO CH.MG-25098-eAPP _0309__Cert Compl Rule-Reg19.pdf

AR.CLICO CH.MG-25098-eAPP _0309__flesch.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Disapproved	09/30/2009

Comments:

This submission is for a new application.

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Disapproved	09/30/2009
Bypass Reason:	N/A - Application only filing		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Disapproved	09/30/2009
Bypass Reason:	N/A - Application only filing		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Disapproved	09/30/2009

Comments:

Attachment:

SERFF Tracking Number:	*MGCC-126107568*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*42368*
Company Tracking Number:	*CH/MG-25098-EAPP (03/09) AR (FOR CLICO)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*eApp (03/09)*		
Project Name/Number:	*eApplication (CH/MG Combo (03/09))/eApp (03/09)*		

AR.CLICO CH.MG-25098-eAPP _0309__Cover Letter.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Variability Statement	Disapproved	09/30/2009

Comments:

The attachment exceeded the maximum size limit allowed by SERFF; therefore, it was split into two separate files.

Attachments:

VAR STMT CHMG-25098-eApp _0309_ AR - File 1 of 2.pdf

VAR STMT CHMG-25098-eApp _0309_ AR - File 2 of 2.pdf

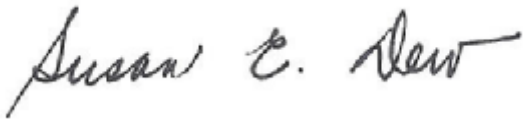
Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: The Chesapeake Life Insurance Company

Form Number(s):

CH/MG-25098-eAPP (03/09) AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



_____
Signature of Company Officer

Susan Dew
_____
Name

Senior Vice President, Associate General Counsel and Chief Compliance Officer
_____
Title

May 8, 2009
_____
Date

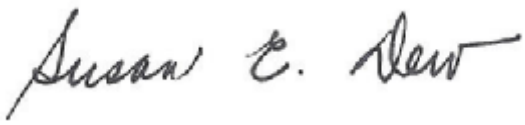
Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Name: Application

Form Number: CH/MG-25098-eAPP (03/09) AR

Flesch Reading Ease Score: 50



_____

Susan Dew
Senior Vice President, Associate General Counsel and Chief Compliance Officer
The Chesapeake Life Insurance Company

May 8, 2009

_____

Date

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9151 Boulevard 26
North Richland Hills
Texas, 76180

May 8, 2009

Commissioner Jay Bradford
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201

RE: The Chesapeake Life Insurance Company
NAIC No. 264-61832 FEIN No. 52-0676509 SERFF Tracking # MGCC-126107568

Form Number:	Description:
CH/MG-25098-eAPP (03/09) AR	Application for Insurance

Supporting Documentation (FOR INFORMATIONAL PURPOSES)
(VAR STMT) CH/MG-25098-eAPP (03/09) AR Statement of Variability

Dear Commissioner Bradford:

The above referenced form, **CH/MG-25098-eAPP (03/09) AR**, is submitted for your review and approval. This form is new and not intended to replace any forms currently approved by your Department.

Upon approval, the enclosed Application form CH/MG-25098-eAPP (03/09) AR is intended to be used to solicit coverage by electronic means with our previously approved group/individual ancillary plans underwritten by our sister company, The MEGA Life and Health Insurance Company, as well as the following individual health plans underwritten by The Chesapeake Life Insurance Company, forthcoming under separate cover:

COMPANY FORM NUMBER	DESCRIPTION
CH-26210 PPO-IP (03/09) AR	Catastrophic Expense Preferred Provider Organization (PPO) Policy
CH-26220 PPO-IP (03/09) AR	Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy

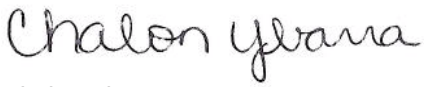
This application is concurrently being filed for review and approval under our sister company, The MEGA Life and Health Insurance Company. It is our hope that this application may also be used to solicit coverage by electronic means for various group/individual health and ancillary plans that may be submitted to the Department for review and approval in the future.

Additionally, enclosed is a very detailed **Statement of Variability** version of this Application form, form number **(VAR STMT) CH/MG-25098-eApp (03/09) AR**. **This version contains extensive information reflecting every possible question and product scenario that could be presented through the electronic application process.** This form is intended to be viewed as supporting documentation, for informational purposes. We understand that this is a lot of information, so please do not hesitate to contact me, Chalon Ybarra, directly (collect, if preferred) at (817) 255-5487, or via email at chalon.ybarra@healthmarkets.com. I am eager to discuss any questions you may have regarding the information enclosed herewith.

Upon approval, this form will be used electronically via an internet-based system currently under development by outside contractor Connecture, Inc. To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

Your assistance in this matter is greatly appreciated.

Sincerely,



Chalon Ybarra
Product Compliance Analyst II
Compliance Department

HealthMarkets®

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P (817) 255-5487 • **F** (817) 255-8153
chalon.ybarra@HealthMarkets.com • www.HealthMarkets.com

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STATEMENT OF VARIABILITY

PRIMARY APPLICANT: [John Doe]
[PRODUCER NAME: [Bobby Greatagent] **]**

APPLICATION SUMMARY

APPLICANT INFORMATION

Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.

Is the Primary Applicant an adult dependent? ❍ Yes ❍ No
{If "Yes":}

Home Phone Number: [123-456-7890] **Cell Phone Number:** [456-123-7899]
Daytime Phone Number: [098-765-4321] **Fax Phone Number:** [987-654-4321]

Is this a child-only application? ❍ Yes ❍ No
{If "Yes":}

If applying for child-only coverage, please enter the oldest child as the Primary Applicant and all additional children, if any, on the Family Members page.
[APPLICANT DEMOGRAPHICS]

First Name: [Fred] **Middle Initial:** [C]
Last Name: [Doe] **Suffix:**
Physical (no PO Box) Address: [1234 Anywhere St]
Apt or Suite Number: [Apt. 123]
City: [Ft. Worth]
State: [Texas] **ZIP Code:** [12345-[6789]]
County: [Tarrant] *{this will auto-generate based on Physical Address Zip Code and State}*

Home Phone Number: [123-456-7890] **Cell Phone Number:** [456-123-7899]
Daytime Phone Number: [098-765-4321] **Fax Phone Number:** [987-654-4321]
Preferred Contact Number: [Daytime]
Best Time to Call: [AM] **Email:** [john.doe@email.com]

Marital Status: ❍ Married ❍ Single [❍ Common Law *{this will only be an option IF the state recognizes this as a legal marriage/unity}*] [❍ Domestic Partnership *{this will only be an option IF the state recognizes this as a legal marriage/unity}*]

[If "Common Law":
Is there any legal impediment to your marriage, including but not limited to, a prior marriage of either party that has not been legally terminated by death or divorce? ❍ Yes ❍ No

Are you living in a husband and wife relationship exclusive of all others? ❍ Yes ❍ No
[If "Yes" –
Indicate the date you entered into your common law marriage: [MM/DD/YY]
In what State did you reside on that date? [state] **]**

Are you presented and known throughout your community as husband and wife? ❍ Yes ❍ No

Are you jointly responsible for each other's common welfare? ❍ Yes ❍ No **]**

SSN: [123-45-6789] **Gender:** ● Male ❍ Female

Date of Birth: [08/04/1994] **Age:** [14] *{auto-calculation based on "Date of Birth" and today's date}*

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STATEMENT OF VARIABILITY

Birthplace: [state] **Height:** [5 feet 10 inches]
Other: [i.e. Russia] **Weight:** [150]

Occupation/Duties: [none]
Is Applicant a U.S. Citizen? ❍ Yes ❍ No
[If "No", explain: [explanation]
How long in the U.S.? [months][years]
Residency Status: ❍ Work Permit ❍ Visa ❍ Other**]**
[If "Visa", Type of Visa: [TYPE]
Expiration Date: [MM/DD/YY] [N/A] **]**
[If "Other", explain: [explanation] **]**

[Guardian Information]

First Name: [John] **Middle Initial:** [C]
Last Name: [Doe] **Suffix:**
Relationship: [Uncle] **Phone Number:** [123-456-7890]
Mailing Address: [1234 Anywhere St] **City:** [Ft. Worth]
Apt or Suite Number: [Apt. 123] **State:** [Texas] **ZIP Code:** [12345-[6789]]

{If "No":}

[APPLICANT DEMOGRAPHICS]

First Name: [John] **Middle Initial:** [C]
Last Name: [Doe] **Suffix:**
Physical (no PO Box) Address: [1234 Anywhere St]
Apt or Suite Number: [Apt. 123]
City: [Ft. Worth]
State: [Texas] **ZIP Code:** [12345-[6789]]
County: [Tarrant] *{this will auto-generate based on Physical Address Zip Code and State}*

Home Phone Number: [123-456-7890] **Cell Phone Number:** [456-123-7899]
Daytime Phone Number: [098-765-4321] **Fax Phone Number:** [987-654-4321]
Preferred Contact Number: [Daytime]
Best Time to Call: [AM] **Email:** [john.doe@email.com]

Marital Status: ● Married ❍ Single [❍ Common Law *{this will only be an option IF the state recognizes this as a legal marriage/unity}*] [❍ Domestic Partnership *{this will only be an option IF the state recognizes this as a legal marriage/unity}*]

[If "Common Law":
Is there any legal impediment to your marriage, including but not limited to, a prior marriage of either party that has not been legally terminated by death or divorce? ❍ Yes ❍ No

Are you living in a husband and wife relationship exclusive of all others? ❍ Yes ❍ No
[If "Yes" –
Indicate the date you entered into your common law marriage: [MM/DD/YY]
In what State did you reside on that date? [state] **]**

Are you presented and known throughout your community as husband and wife? ❍ Yes ❍ No

Are you jointly responsible for each other's common welfare? ❍ Yes ❍ No **]**

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STATEMENT OF VARIABILITY

SSN: [123-45-6789] **Gender:** ● Male ❍ Female
Date of Birth: [08/04/1976] **Age:** [32] *{auto-calculation based on "Date of Birth" and today's date}*
Birthplace: [state] **Height:** [6 feet 2 inches]
Other: [i.e. Russia] **Weight:** [220]

Occupation/Duties: [none]
Is Applicant a U.S. Citizen? ❍ Yes ❍ No
[If "No", explain: [explanation]
How long in the U.S.? [months][years]
Residency Status: ❍ Work Permit ❍ Visa ❍ Other**]**
[If "Visa", Type of Visa: [TYPE]
Expiration Date: [MM/DD/YY] [N/A] **]**
[If "Other", explain: [explanation] **]**

[Mailing Address]
Mailing Address: [1234 Anywhere St]
Apt or Suite Number: [Apt. 123]
City: [Ft. Worth]
State: [Texas] **ZIP Code:** [12345-[6789]]

[Coverage Information]
Request for Special Effective Date: [01/15/2009] *{If Applicant does not have a special request, then this will be blank}*

[Additional Detail]
{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans}

1. Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father? ❍ Yes ❍ No
{If "Yes":} **[** Please indicate the name of each expectant person, his or her relationship to the Primary Applicant and the estimated date(s) of delivery.
[details] **]**

2. Is the Applicant, spouse or any dependent child (even if not proposed for insurance) being tested for or receiving treatment for infertility/fertility, in the process of adoption or surrogacy (with anyone, whether or not this person is applying for coverage? ❍ Yes ❍ No
{If "Yes":} **[** Please provide additional details.
[details] **]**

3. Has the Applicant used tobacco products in the past twelve (12) months? ❍ Yes ❍ No
{If "Yes":} **[** Please provide smoking/tobacco history over past twelve months:
[details] **]**

4. Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License?
❍ Yes ❍ No
{If "Yes":} **[** Please indicate the reason(s) for Driver's License suspension or revocation.
[details] **]**

5. Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? ❍ Yes ❍ No
{If "Yes":} **[** Please indicate the date for each DWI and DUI.
[details] **]**

6. Has the Applicant ever been convicted or prosecuted for any criminal activity? ❍ Yes ❍ No

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STATEMENT OF VARIABILITY

{If "Yes":} **[** Please describe each offense and indicate the date(s) of prosecution.
[details] **]**

[Income and Disability Detail]

{The following questions are only applicable if Primary or Spouse Applicant(s) chose the "Income Protection Plan" (Accident-Only Disability Income Insurance Certificate) (Form # [25916-C]) or the "Income Protection Plus Plan" (Disability Income Insurance Certificate) (Form # [25915-C]); not applicable for Dependent Applicant(s).}

1. Does the Applicant currently have Disability Income Insurance (either through your employer or as an individual policy)? ❍ Yes ❍ No
Company: [company name]
Monthly Benefit: [$$$$$]
Elimination Period: [time period]
Length of Coverage: [six months]

{If "Yes"}

2. Are you currently disabled or receiving disability benefits? ❍ Yes ❍ No

3. What is your annual gross income? [$$$$$$$$$]

4. How many hours per week do you work? [55] **Hours**

5. Tell us about your occupation and describe your specific job duties.
Job Description: [route sales manager]
Duties: [manage sales on delivery route; establish new clients; deliver goods to existing clients]

6. As part of your normal activities, do you spend more than 25% performing manual labor/duties such as lifting, bending, stooping, pulling, pushing and/or carrying objects over 10 pounds? ❍ Yes ❍ No

FAMILY MEMBERS
[Family Member 1]

First Name: [Jane] **Middle Initial:** [A]
Last Name: [Doe] **Suffix:**
SSN: [123-45-6789]
Date of Birth: [08/19/1978] **Age:** [30] *{auto-calculation based on "Date of Birth" and today's date}*
Relationship [spouse] **Gender:** ❍ Male ● Female
Height: [5 feet 4 inches] **Weight:** [130]
Birthplace: [state] **Other:** [i.e. Russia]

Occupation/Duties: [working woman]
Is Applicant a U.S. Citizen? ❍ Yes ❍ No
[If "No", explain: [explanation]
How long in the U.S.? [months][years]
Residency Status: ❍ Work Permit ❍ Visa ❍ Other**]**
[If "Visa", Type of Visa: [TYPE]
Expiration Date: [MM/DD/YY] [N/A] **]**
[If "Other", explain: [explanation] **]**
Same address as Primary Applicant? ❍ Yes ❍ No *{If "No", will ask for Family Member's mailing address}*

[Additional Detail]
{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans}

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STATEMENT OF VARIABILITY

1. Has the Applicant used tobacco products in the past twelve (12) months? ❍ Yes ❍ No
{If "Yes":} **[** Please provide smoking/tobacco history over past twelve months:
[details] **]**

2. Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License?
❍ Yes ❍ No
{If "Yes":} **[** Please indicate the reason(s) for Driver's License suspension or revocation.
[details] **]**

3. Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? ❍ Yes ❍ No
{If "Yes":} **[** Please indicate the date for each DWI and DUI.
[details] **]**

4. Has the Applicant ever been convicted or prosecuted for any criminal activity? ❍ Yes ❍ No
{If "Yes":} **[** Please describe each offense and indicate the date(s) of prosecution.
[details] **]**

[Income and Disability Detail]

{The following questions are only applicable if Primary or Spouse Applicant(s) chose the "Income Protection Plan" (Accident-Only Disability Income Insurance Certificate) (Form # [25916-C]) or the "Income Protection Plus Plan" (Disability Income Insurance Certificate) (Form # [25915-C]); not applicable for Dependent Applicant(s).}

1. Does the Applicant currently have Disability Income Insurance (either through your employer or as an individual policy)? ❍ Yes ❍ No
Company: [company name]
Monthly Benefit: [$$$$$]
Elimination Period: [time period]
Length of Coverage: [six months]

{If "Yes"}
2. Are you currently disabled or receiving disability benefits? ❍ Yes ❍ No

3. What is your annual gross income? [$$$$$$$$$]

4. How many hours per week do you work? [55] **Hours**

5. Tell us about your occupation and describe your specific job duties.
Job Description: [route sales manager]
Duties: [manage sales on delivery route; establish new clients; deliver goods to existing clients]

6. As part of your normal activities, do you spend more than 25% performing manual labor/duties such as lifting, bending, stooping, pulling, pushing and/or carrying objects over 10 pounds? ❍ Yes ❍ No

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STATEMENT OF VARIABILITY

[Family Member 2]

First Name:	[Baby]	**Middle Initial:**	[B]
Last Name:	[Doe]	**Suffix:**	
SSN:	[123-45-6789]		
Date of Birth:	[01/17/2006]	**Age:**	[2] *{auto-calculation based on "Date of Birth" and today's date}*
Relationship	[dependent]	**Gender:**	● Male ❍ Female
Height:	[3 feet 1 inches]	**Weight:**	[42]
Birthplace:	[TX]	**Other:**	[i.e. Russia]

Occupation/Duties: [none]
Is Applicant a U.S. Citizen? ❍ Yes ❍ No
[If "No", explain: [explanation]
How long in the U.S.? [months][years]
Residency Status: ❍ Work Permit ❍ Visa ❍ Other**]**
[If "Visa", Type of Visa: [TYPE]
Expiration Date: [MM/DD/YY] [N/A] **]**
[If "Other", explain: [explanation] **]**
Same address as Primary Applicant? ❍ Yes ❍ No *{If "No", will ask for Family Member's mailing address}*
Is this an adoption/guardianship? ❍ Yes ❍ No
Is Dependent Applicant between the ages of 19 and 24? ❍ Yes ❍ No
Is this Applicant a full-time student? ● Yes ❍ No
[[If "Yes",] Name of School: [Great University] **]**
Explain: [details]
Is this Applicant incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on the Primary Applicant for support and maintenance? ❍ Yes ❍ No

[Additional Detail]
{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans}

1. Has the Applicant used tobacco products in the past twelve (12) months? ❍ Yes ❍ No
{If "Yes":} **[** Please provide smoking/tobacco history over past twelve months:
[details] **]**

2. Has the Applicant ever had or does the Applicant currently have a suspended or revoked Driver's License?
❍ Yes ❍ No
{If "Yes":} **[** Please indicate the reason(s) for Driver's License suspension or revocation.
[details] **]**

3. Has the Applicant ever received any citations for driving while under the influence (e.g. DWI or DUI)? ❍ Yes ❍ No
{If "Yes":} **[** Please indicate the date for each DWI and DUI.
[details] **]**

4. Has the Applicant ever been convicted or prosecuted for any criminal activity? ❍ Yes ❍ No
{If "Yes":} **[** Please describe each offense and indicate the date(s) of prosecution.
[details] **]**

CHOICE OF COVERAGE
The following [Certificates] [Policies] are underwritten by The Chesapeake Life Insurance Company:

[Plan Name]	[Applicant(s)]	[Description]	[Monthly Premium]
[Chesapeake ESSENTIAL Fit	[John Doe]	**[Calendar Year Deductible:**	[$$$$.$$]

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STATEMENT OF VARIABILITY

(Catastrophic Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26210 PPO-IP (03/09) AR] (EFIL)]	[Jane Doe] [Baby Doe]	[$2,500 per Person, In-Network / $5,000 per Person, Out-of-Network $5,000 per Family, In-Network / $10,000 per Family, Out-of-Network] [$5,000 per Person, In-Network / $10,000 per Person, Out-of-Network $10,000 per Family, In-Network / $20,000 per Family, Out-of-Network] [$7,500 per Person, In-Network / $15,000 per Person, Out-of-Network $15,000 per Family, In-Network / $30,000 per Family, Out-of-Network] [$10,000 per Person, In-Network / $20,000 per Person, Out-of-Network [$20,000 per Family, In-Network / $40,000 per Family, Out-of-Network] [$15,000 per Person, In-Network / $30,000 per Person, Out-of-Network [$30,000 per Family, In-Network / $60,000 per Family, Out-of-Network] [$20,000 per Person, In-Network / $40,000 per Person, Out-of-Network [$40,000 per Family, In-Network / $80,000 per Family, Out-of-Network] **]** **Coinsurance:** [100% In-Network / 70% Out-of-Network] [90% In-Network / 60% Out-of-Network] [80% In-Network / 50% Out-of-Network] [70% In-Network / 50% Out-of-Network] **Calendar Year / Lifetime Maximum:** [$1,000,000 / $2,000,000] [$1,000,000 / $4,000,000] [$2,000,000 / $8,000,000] **[Coinsurance Maximum (per Calendar Year):** [$2,500 per Person, In-Network / $5,000 per Person, Out-of-Network $5,000 per Family, In-Network / $10,000 per Family, Out-of-Network] [$5,000 per Person, In-Network / $10,000 per Person, Out-of-Network $10,000 per Family, In-Network / $200,000 per Family, Out-of-Network] [$10,000 per Person, In-Network / $20,000	[Incl.]

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STATEMENT OF VARIABILITY

		per Person, Out-of-Network $20,000 per Family, In-Network / $40,000 per Family, Out-of-Network] [$15,000 per Person, In-Network / $30,000 per Person, Out-of-Network $30,000 per Family, In-Network / $60,000 per Family, Out-of-Network] **]** **Option of Network:** [023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]	
[Chesapeake CLASSIC Fit (Catastrophic Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26210 PPO-IP (03/09) AR] (CFIL)]	[John Doe] [Jane Doe] [Baby Doe]	**[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible:** [$1,000 per Person, In-Network / $2,000 per Person, Out-of-Network] [$1,500 per Person, In-Network / $3,000 per Person, Out-of-Network] [$2,000 per Person, In-Network / $4,000 per Person, Out-of-Network] [$2,500 per Person, In-Network / $5,000 per Person, Out-of-Network] [$3,000 per Person, In-Network / $6,000 per Person, Out-of-Network] [$3,500 per Person, In-Network / $7,000 per Person, Out-of-Network] [$4,000 per Person, In-Network / $8,000 per Person, Out-of-Network] [$4,500 per Person, In-Network / $9,000 per Person, Out-of-Network] [$5,000 per Person, In-Network / $10,000 per Person, Out-of-Network] [$7,500 per Person, In-Network / $15,000 per Person, Out-of-Network] [$10,000 per Person, In-Network / $20,000 per Person, Out-of-Network] **]** **Coinsurance:** [100% In-Network / 80% Out-of-Network] [90% In-Network / 70% Out-of-Network] [80% In-Network / 60% Out-of-Network] [70% In-Network / 50% Out-of-Network] **Calendar Year / Lifetime Maximum:** [$1,000,000 / $2,000,000] [$1,000,000 / $4,000,000] [$2,000,000 / $8,000,000] **[Coinsurance Maximum (per Period of Treatment):**	[$$$$.$$] [Incl.]

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STATEMENT OF VARIABILITY

		[$2,500 per Person, In-Network / $5,000 per Person, Out-of-Network] **]** [$5,000 per Person, In-Network / $10,000 per Person, Out-of-Network] [$10,000 per Person, In-Network / $20,000 per Person, Out-of-Network] **]** **Option of Network:** [023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]	
[Chesapeake BASIC Fit (Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy) (Form # [CH-26220 PPO-IP (03/09) AR] (BFIL)]	[John Doe] [Jane Doe] [Baby Doe]	**[Per Period of Treatment & Per Calendar Year (for all other Outpatient Covered Services) Deductible:** [$2,000 per Person, In-Network / $4,000 per Person, Out-of-Network] [$2,500 per Person, In-Network / $5,000 per Person, Out-of-Network] [$3,000 per Person, In-Network / $6,000 per Person, Out-of-Network] [$3,500 per Person, In-Network / $7,000 per Person, Out-of-Network] [$4,000 per Person, In-Network / $8,000 per Person, Out-of-Network] [$4,500 per Person, In-Network / $9,000 per Person, Out-of-Network] [$5,000 per Person, In-Network / $10,000 per Person, Out-of-Network] [$5,500 per Person, In-Network / $11,000 per Person, Out-of-Network] [$7,500 per Person, In-Network / $15,000 per Person, Out-of-Network] [$10,000 per Person, In-Network / $20,000 per Person, Out-of-Network] **]** **Coinsurance:** [80% In-Network / 60% Out-of-Network] [70% In-Network / 60% Out-of-Network] [70% In-Network / 50% Out-of-Network] **Lifetime Maximum:** [$500,000] [$1,000,000] **Hospital Inpatient & Miscellaneous / Inpatient Surgeon Maximum Benefit Amount:** [$7,500 / $3,000] [$10,000 / $4,000] [$15,000 / $6,000]	[$$$$.$$] [Incl.]

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STATEMENT OF VARIABILITY

		[$20,000 / $8,000] [$25,000 / $10,000] [$30,000 / $12,000] [$35,000 / $14,000] [$40,000 / $16,000] [$50,000 / $18,000] **Outpatient Surgery Facility / Outpatient Surgeon Maximum Benefit Amount:** [$3,750 / $1,000] [$5,000 / $2,000] [$7,500 / $3,000] [$10,000 / $4,000] [$12,500 / $5,000] [$15,000 / $6,000] [$17,500 / $7,000] [$20,000 / $8,000] [$25,000 / $9,000] **Option of Network:** [023-Private Health Care Systems (PHCS)] [074-Texas True Choice] [075-HealthSmart]	
[Physician Office Services Benefit Rider (Form # CH-26223-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	**Copayment (per Person, per Visit):** [$25 In-Network / $50 Out-of-Network] [$50 In-Network / $100 Out-of-Network] [$75 In-Network / $150 Out-of-Network] **Visit Limitation (per Person, per Calendar Year):** [unlimited] [2] [4]	[$$$$.$$] [Incl.]
[Outpatient Accident Expense Benefit Rider (Form # CH-26221-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	**Copayment (In-Network and Out-of-Network):** [$50] [$100] [$150] **Maximum Benefit Amount (per Person, per Calendar Year):** [$500] [$1,000] [$1,500]	[$$$$.$$] [Incl.]
[Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form # CH-26224-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	**[Copayment][Facility Fee] (per Person, per Visit):** [$50 In-Network / $100 Out-of-Network] [$75 In-Network / $150 Out-of-Network] [$100 In-Network / $200 Out-of-Network] [$150 In-Network / $300 Out-of-Network] **[Combined Visit Limitation (per Person, per Calendar Year):** [15] [20] [30] **]**	[$$$$.$$] [Incl.]

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STATEMENT OF VARIABILITY

[Continued Care Benefit Rider (Form # CH-26225-IR (03/09) AR)]	[John Doe] [Jane Doe] [Baby Doe]		[$$$$.$$] [Incl.]
[Outpatient Diagnostic Services Benefit Rider (Form # CH-26226-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]	**[[Copayment][Facility Fee] (per Person, per Visit):** [$75 In & Out-of-Network] [$150 In & Out-of-Network] [$250 In & Out-of-Network] [$100 In-Network / $200 Out-of-Network] [$250 In-Network / $500 Out-of-Network] **]** **[Maximum Benefit Amount (per Person, per Day):** [$500] [$750] [$1,000] [$1,250] [$1,500] **]** **[Maximum Benefit Amount (per Person, per Calendar Year):** [$2,500] [$3,000] [$5,000] [$7,500] **]**	[$$$$.$$] [Incl.]
[Covered Services Extension Rider (Form # CH-26228-IR (03/09))]	[John Doe] [Jane Doe] [Baby Doe]		[$$$$.$$] [Incl.]
[Rate Guarantee Rider (Form # CH-26205-IR (08/08))]	[John Doe] [Jane Doe] [Baby Doe]	**Guarantee Level:** [24] [36] months	[$$$$.$$] [Incl.]
[Pregnancy/Childbirth Benefit Rider (Form # [CH-26213-IR (03/09) AR])]	[John Doe] [Jane Doe] [Baby Doe]	**Maximum Benefit Amount (per pregnancy/childbirth):** [$1,000] [$2,000] [$3,000] [$4,000] [$6,000]	[$$$$.$$] [Incl.]
[Prescription Drug Expense Rider (Form # [(CH-26214-IR (03/09) AR)]]	[John Doe] [Jane Doe] [Baby Doe]	**Maximum Benefit (per person, Calendar Year):** [$1,500][$2,000] [$5,000] **Generic / Brand Drug Deductible (per Person, per Calendar Year):** **[** [$0 / $50] [$0 / $250] **]** **Retail:** Generic Preferred Drugs, [30] day supply: [100%] less [$5] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [$15] copayment Brand Preferred Drugs, [30] day supply discount: [50%] Brand Non-Preferred Drugs, [30] day supply discount: [25%][50%] **Mail-Order:** Generic Preferred Drugs, [90] day supply: [100%] less [$15] copayment	[$$$$.$$] [Incl.]

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STATEMENT OF VARIABILITY

		Generic Non-Preferred Drugs, [90] day supply: [100%] less [$45] copayment Brand Preferred Drugs, [90] day supply discount: [50%] Brand Non-Preferred Drugs, [90] day supply discount: [25%]	
[Prescription Drug Expense Rider (Form # [(CH-26222-IR (03/09) AR)]]	[John Doe] [Jane Doe] [Baby Doe]	**Maximum Benefit (per Person, per Calendar Year):** [$500] [$1,000] [$1,500] **Deductible (per Person, per Calendar Year):** [$50] [$75] [$100] [$150] [$250] **Retail:** Generic Preferred Drugs, [30] day supply: [100%] less [$5] [$10] [$15] copayment Generic Non-Preferred Drugs, [30] day supply: [100%] less [$20] [$25] [$30] copayment Brand Name Drugs, [30] day supply discount: [25%] **Mail-Order:** Generic Preferred Drugs, [90] day supply: [100%] less [$10] [$20] [$30] copayment Generic Non-Preferred Drugs, [90] day supply: [100%] less [$40] [$50] [$60] copayment Brand Name Drugs, [90] day supply discount: [25%]	[$$$$.$$] [Incl.]

The following Certificates/Policies are underwritten by The MEGA Life and Health Insurance Company:

[MEGA Vision Plan (Vision Insurance Policy) (Form # [(26023-IP (5/07) AR)]) (VSIN)]	[John Doe] [Jane Doe] [Baby Doe]	NETWORK: Deductible: [$0] Comprehensive Eye Exam: [100%] Corrective Spectacle Lenses: [100%] Corrective Contact Lenses (Non-Disposable or Disposable): [$40] Corrective Contact Lenses (Therapeutic): [100%] Frames: [Not Covered] Contact Lens Fitting: [Not Covered] Follow-Up Visits: [Not Covered] NON-NETWORK: Deductible: [$0] Comprehensive Eye Exam: [$30] Corrective Spectacle Lenses: [75%] Corrective Contact Lenses (Non-Disposable or Disposable): [$30] Corrective Contact Lenses (Therapeutic): [75%] Frames: [Not Covered]	[$$$$.$$] [Incl.]

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STATEMENT OF VARIABILITY

		Contact Lens Fitting: [Not Covered] Follow-Up Visits: [Not Covered]	
[MEGA Bronze (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLB)] **[MEGA Silver (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLS)]** **[MEGA Gold (Dental Insurance Policy) Form # [26099-IP (1/08)] (DTLG)]**	[John Doe] [Jane Doe] [Baby Doe]	[BRONZE (Option A-Diagnostic & Preventive): Deductible: [$0]] [SILVER (Option B-Premiere): Deductible (per person, per year): [$100] Benefit Maximum (per person, per year): [$1000]] [GOLD (Option C-Deluxe): Deductible (per person, per lifetime): [$100] Benefit Maximum (per person, per year): [$1200] Orthodontics Benefit Maximum (per person, per month): [$50] Orthodontics Benefit Maximum (per person, per lifetime): [$1200]]	[$$$$.$$] [Incl.]
[MEGA CancerWise (Cancer Benefit Policy) (Form # [(26055-IP (5/07) AR)]) (ECAN)]	[John Doe] [Jane Doe] [Baby Doe]	First Diagnosis Cancer Benefit Amount (per person, per lifetime): [$10,000] [$20,000] [$30,000] [$40,000] [$50,000]	[$$$$.$$] [Incl.]
[Income Protection (Accident-Only Disability Income Insurance Certificate) (Form # [25916-C]) (DIGP)]	[John Doe] [Jane Doe]	Monthly Indemnity Benefit (per disabled person): [$500] [$1000] [$1500] [$2000] Elimination Period (per disabled person): [14] [30] days	[$$$$.$$] [Incl.]
[Income Protection Plus (Disability Income Insurance Certificate) (Form # [25915-C]) (DSGP)]	[John Doe] [Jane Doe]	Monthly Indemnity Benefit (per disabled person): [$500] [$1000] [$1500] [$2000] [Blue Collar: Yes] [White Collar: Yes]	[$$$$.$$] [Incl.]
[Waiver of Premium Benefit Rider (Form # [25917])]	[John Doe] [Jane Doe]		[$$$$.$$] [Incl.]
[Endorsement Return of Premium Benefit (Form # [25918])]	[John Doe] [Jane Doe]		[$$$$.$$] [Incl.]
[Critical Care Plus (Specified Disease/Condition Or Major Organ Transplant Certificate) (Form # [25936-C]) (CI01)]	[John Doe] [Jane Doe] [Baby Doe]	First Occurrence Benefit Amount (per person, per lifetime): [$10,000] [$15,000] [$20,000] [$30,000] [$40,000] [$50,000] [$60,000]	[$$$$.$$] [Incl.]

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STATEMENT OF VARIABILITY

[MEGA Accident Advantage (Accidental Injury Only Insurance Certificate) (Form # [26038-C]) (ASLG)]	[John Doe] [Jane Doe] [Baby Doe]	Accidental Injury Benefit Amount, per person, per year: [$5000] [$10,000] [$15,000] [$25,000]	[$$$$.$$] [Incl.]
[Accident Expense Insurance Plan (Accident Catastrophic Expense Plan Certificate of Insurance) (Form # [25314]) (IA08)]	[John Doe] [Jane Doe] [Baby Doe]	Deductible, per person, per occurrence: [$0] [$600] [$1,200] [$2,400] Maximum Benefit, per person, per occurrence: [$6,000] [$12,000] [$24,000] Coinsurance: [100%] [80%] [50%]	[$$$$.$$] [Incl.]
[Accident Expense Benefit Rider (Form # [25096])]	[John Doe] [Jane Doe] [Baby Doe]	Deductible, per injury: [$0] [$100] Maximum Benefit, per injury [$600] [$1,200]	[$$$$.$$] [Incl.]
[Direct Benefit (Hospital Confinement Indemnity Certificate) (Form # [25874-C]) (DB01)]	[John Doe] [Jane Doe] [Baby Doe]	Daily Benefit Amount (per person): [$100] [$200] [$250] [$300] [$400] [$500] [$1,000] [$1,500]	[$$$$.$$] [Incl.]
[023-Private Health Care Systems (PHCS)] **[074-Texas True Choice]** **[075-HealthSmart]**			[$$$$.$$] [Incl.]
[Certificate][Policy] Fee			[$$$.$$] [Incl.]
		Total Estimated Recurring Payment:	[$$$$.00]
		Total Initial Payment:	[$$$$.00]

The estimated premium is provided prior to review by the Underwriting Department and may change after underwriting review. You will be notified if there is any change to the estimated recurring payment as a result of underwriting review.

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{The following section is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans}

PHYSICIAN DETAILS (Name of current Physician and any other Physician or specialist seen in the past 12 months)

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Primary Applicant: [John Doe]
Physician/Specialist Name: [James Brown, MD]
Phone Number: [123-456-7890]
Address Line 1: [1234 Anywhere Street]
Address Line 2: [Suite ABC]
City: [My Town]
State: [My State] **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]
Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Spouse Applicant: [Jane Doe]
Physician/Specialist Name: [James Brown, MD]
Phone Number: [123-456-7890]
Address Line 1: [1234 Anywhere Street]
Address Line 2: [Suite ABC]
City: [My Town]
State: [My State] **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]
Recommendation(s)? [recommendations]

APPLICANT'S PRIMARY PHYSICIAN/SPECIALIST:

Dependent Applicant: [Baby Doe]
Physician/Specialist Name: [Baby Doctor, MD]
Phone Number: [123-456-7890]
Address Line 1: [1234 Anywhere Street]
Address Line 2: [Suite ABC]
City: [My Town]
State: [My State] **ZIP Code:** [09876-5432]

LAST PHYSICIAN/SPECIALIST VISIT:

When was the last time the Applicant visited ANY Physician/Specialist/Urgent Care Center/Hospital? [MM/YYYY]
Reason(s)? [reason]
Result(s)? [results]
Recommendation(s)? [recommendations]

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{The following section is only applicable if "10 Year Term Life Plan" (Renewable Term Life Insurance Plan Certificate, form 25919-IP (1/09) TX is chosen. This section will replicate for every Applicant that applied for the Renewable Term Life Insurance Plan Certificate.}

BENEFICIARY INFORMATION
[John Doe] Beneficiary Information Details

BENEFICIARY 1

First Name:	[Jane]	**Middle Initial:**	[A]
Last Name:	[Doe]	**Suffix:**	
Beneficiary Relationship:	[Wife]	**Percentage:**	[XXX%]
Other:			
City:	[Fabulous]		
State:	[State]		
Zip:	[12345-9876]		

BENEFICIARY 2

First Name:	[Baby]	**Middle Initial:**	[B]
Last Name:	[Doe]	**Suffix:**	
Beneficiary Relationship:	[Son]	**Percentage:**	[XXX%]
Other:			
City:	[Fabulous]		
State:	[State]		
Zip:	[12345-9876]		

PRIOR COVERAGE

{The following question is NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (it is applicable for all other plans}

MEDICARE/MEDICAID

Is any Applicant eligible for or currently covered under Medicare or Medicaid? ❍ Yes ❍ No

[If "Yes", who?	**Reason**	
❍ [John Doe]	[Financial]	[Medical]
❍ [Jane Doe]	[Financial]	[Medical]
❍ [Baby Doe]	[Financial]	[Medical]

CURRENT HEALTH INSURANCE

During the past two years, has any person to be insured had insurance declined, postponed, had a waiver applied, or charged additional premium for life, disability or health insurance or had such insurance rescinded? ❍ Yes ❍ No

If "Yes", who?	**Date**	**Reason**	**Name of Company**
[John Doe]	[12/2000]	[XYZ Reason]	[ABC Insurance]
[Jane Doe]	[05/2000]	[LMNOP Reason]	[DEF Insurance]

Does any Applicant currently have health insurance or has any Applicant had health insurance within the past 12 months? ❍ Yes ❍ No

[If "Yes", has coverage been in force within the past 60 days? ❍ Yes ❍ No] [If "No", date of cancellation: [MM/YYYY]]

If "Yes", who?	**Group or Individual Coverage?**	**Name of Company**	**Certificate/Policy Number**	**Type of Coverage**	**Date of Issue**
[Jane Doe]	[Group]	[HIJ Insurance]	[ABC12345]	[Accident-Only]	[05/2007]

[*{If "Yes"}* **Will existing health coverage be replaced or changed if proposed health coverage is issued?** ❍ Yes ❍ No **]**

If "Yes", who?	**On Issue?**	**Date of Cancellation**
[Jane Doe]	[Yes]	[10/2008

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CURRENT LIFE INSURANCE
Does any Applicant currently have life insurance or annuities? ❍ Yes ❍ No

[If "Yes", who?
❍ [John Doe]
❍ [Jane Doe]
❍ [Baby Doe]

Will the insurance applied for replace or otherwise reduce in value any life insurance or annuities now in force?
❍ Yes ❍ No

[If "Yes", details: [details]

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy/certificate or contract? ❍ Yes ❍ No

Are you considering using funds from your existing policies/certificates or contracts to pay premiums due on the new policy/certificate or contract? ❍ Yes ❍ No

[If you answered "Yes" to either of the above questions, list each existing policy/certificate or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy/certificate or contract number if available) and whether each policy/certificate or contract will be replaced or used as a source of financing:

INSURED OR ANNUITANT	INSURER NAME	CONTRACT OR CERTIFICATE #	REPLACED (R) OR FINANCING (F)
[John Doe]	[ABC Insurance]	[POL123456]	R

[*{If "Replaced (R)"}* The existing policy/certificate or contract is being replaced because: [reason for replacement] **]**

{The following questions are NOT applicable for the "MEGA Dental Plan" (Dental Insurance Policy, form 26099-IP (1/08)) and/or the "MEGA Vision Plan" (Vision Insurance Policy, form 26023-IP (5/07) AR) only (they are applicable for all other plans}

[MEDICAL QUESTIONS

Have you or any Applicant **EVER** had symptoms, been diagnosed, received medical advice or been treated for:

1. Hazardous Activities or Sports - does Any Applicant to be insured engage in any hazardous sport or activity? ❍ Yes ❍ No
[If "Yes", is it professionally or for recreation? ❍ Professionally ❍ Recreationally]

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

2. Heart or Cardiovascular Conditions/Disorders including but not limited to - Heart attack, stroke, myocardial infarction, hypertension (high blood pressure), angina pectoris, transient ischemia attack (TIA), coronary artery disease, any form of heart surgery, coronary artery surgery, heart related arteriogram, angioplasty or pacemaker, or disease or disorder of the heart or circulatory system? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

3. Endocrine Disorders including but not limited to – Diabetes (high blood sugar), hypoglycemia (low blood sugar), goiter, thyroid disorder, or obesity? ❍ Yes ❍ No

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Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

4. Blood Disorders including but not limited to - Blood or spleen disorder, including anemia, leukemia, high cholesterol, or hyperlipidemia? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

5. Gynecological Disorders including but not limited to – male or female reproductive organ disorder or disease, including breast disorder or augmentation? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

6. Cancer / Tumor or any benign or malignant growths, including but not limited to - Cancer, cyst, tumor, or neoplasm? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

7. Respiratory Disorders including but not limited to - Respiratory disorder, including asthma, bronchitis, COPD (Chronic Obstructive Pulmonary Disease), emphysema, lung disease, sleep apnea, or breathing problems? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

8. Urinary Tract Disorders including but not limited to - Kidney, bladder, urinary tract, stones, or prostate disorders? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

9. Digestive Tract Disorders including but not limited to – GERD (gastroesophageal reflux disease), Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis, hepatitis, or pancreatitis? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

10. Colon Disorders including but not limited to - Hernia, chronic diarrhea, bloody stool, hemorrhoids, polyps, or rectal disorders? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

11. Eye, ear, nose, or throat disorders - Eye, ear, nose, or throat disorders? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

12. Skin Disorders including but not limited to - Skin disorders, burns, lacerations, dermatitis, boils, chronic rashes, or melanoma? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

13. Musculoskeletal Disorders including but not limited to - Back, shoulder, hands or feet, spine, arm or leg disorder, or arthritis, gout, bursitis, or neuritis? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

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14. Complications of Pregnancy including but not limited to - Cesarean section? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

15. Brain Disorders including but not limited to - Epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury, or chronic headaches? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

16. Mental and Nervous Disorders including but not limited to - Depression, anxiety, alcoholism, alcohol abuse, drug abuse, or drug addiction? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

17. Connective Tissue Disorders including but not limited to - Hodgkin's or Non-Hodgkin's Lymphoma, cystic fibrosis, collagen disease, or connective tissue disease? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

18. Abnormal Test Results - Any abnormal results of a cancer test such as a PAP Smear, mammogram, CEA (carcinoembryonic antigen), PSA (prostate specific antigen), or chest X-ray? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

19. Symptoms of other Medical Conditions - Abnormal bleeding, swollen or enlarged prostate, or night sweats? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

20. Muscular Disorders - Any neurological disease or disorder that would include numbness of any extremity, any muscular disease or disorder, or loss of use of any limbs? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

21. AIDS / HIV - Have you or any Applicant(s) ever been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an AIDS-related test? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

22a. Recent Medical Treatment - WITHIN THE LAST 5 YEARS, have you had any other medical or surgical advice, hospitalizations, treatment, operations, or testing? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

22b. Recent Medical Treatment – WITHIN THE LAST 3 YEARS, have you or any Applicant taken, been advised to take, or been prescribed any medication(s),

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including any which were not filled? ❍ Yes ❍ No

[If "Yes", what condition(s) is the prescribed medication for?] [conditions]

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]

22c. Recent Medical Treatment – Have you or any Applicant(s) been advised to have additional testing, lab work, surgical or medical treatment, or had such that has not yet been completed? ❍ Yes ❍ No

Select all Applicants this question applies to: ❍ [John Doe] ❍ [Jane Doe] ❍ [Baby Doe]]

{The following questions are only applicable if Applicant(s) chose the "Critical Care/Plus Plan" (Specified Disease/Condition Or Major Organ Transplant Certificate) (Form # [25936-C])}

23. Family History - Have either of your parents, brothers, or sisters been diagnosed or been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer disease, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or diabetes? ❍ Yes ❍ No

24. Transplant - Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? ❍ Yes ❍ No

25. Critical Illness - Have you or any Applicant ever consulted with or been treated by a physician for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke, disease of the heart or blood vessels, renal failure, multiple sclerosis, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or Alzheimer disease? ❍ Yes ❍ No

{The following section/questions will only be asked for the Applicants who selected "Yes" to any of the questions in the "MEDICAL QUESTIONS" section above.}

[ADDITIONAL HEALTH INFORMATION [section 1]

[Based on previous answers, additional information is required. Please complete the requested information for the indicated Applicant. Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.]

Health Information For: [John Doe]

[1] HAZARDOUS ACTIVITIES OR SPORTS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #1: "Do you engage in any hazardous sport or activity…"}*

Select all conditions that apply:

❍ Hot Air Ballooning	❍ Fire Fighting	❍ Flying for Hunting
❍ Explosive Transportation	❍ Stunt Flying	❍ Crop Dusting
❍ Ultra Lights	❍ Experimental Aircraft Flying	❍ Helicopter / Rotorcraft Flying
❍ Other Aviation Related Activities	❍ Flight Testing	❍ Other Sports Activities

[2] HEART OR CARDIOVASCULAR CONDITIONS/DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #2: "Heart attack, stroke, myocardial infarction…"}*

Select all conditions that apply:

❍ Heart Attack	❍ Stroke	❍ Myocardial Infarction
❍ Hypertension	❍ Angina Pectoris	❍ Transient Ischemia Attack (TIA)
❍ Coronary Artery Disease	❍ Any Form of Heart Surgery	❍ Coronary Artery Surgery
❍ Heart-related Arteriogram	❍ Angioplasty	❍ Pacemaker
❍ Disease or Disorder of the Heart	❍ Disease or Disorder of the Circulatory System	

[3] ENDOCRINE DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #3: "Diabetes, hypoglycemia, goiter…"}*

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Select all conditions that apply:
❍ Diabetes ❍ Hypoglycemia ❍ Goiter ❍ Thyroid Disorder
❍ Obesity

[4] BLOOD DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #4: "Blood or spleen disorder…"}*
Select all conditions that apply:
❍ Spleen Disorder ❍ Anemia ❍ Leukemia ❍ Other Blood Disorder(s)

[5] GYNECOLOGICAL DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #5: "Breast or reproductive organ disorder"}*
Select all conditions that apply:
❍ Breast Disorder ❍ Reproductive Organ Disorder

[6] CANCER / TUMOR*{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #6: "Cancer, cyst, tumor, or neoplasm"}*
Select all conditions that apply:
❍ Cancer ❍ Cyst ❍ Tumor ❍ Neoplasm

[7] RESPIRATORY DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #7: "Respiratory disorder, including asthma…'}*
Select all conditions that apply:
❍ Asthma ❍ Bronchitis ❍ COPD (Chronic Obstructive Pulmonary Disease)
❍ Emphysema ❍ Lung Disease ❍ Breathing Problems
❍ Other Respiratory Disorder(s)

[8] URINARY TRACT DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #8: "Kidney, urinary bladder, urinary tract…"}*
Select all conditions that apply:
❍ Kidney Disorder ❍ Urinary Bladder Disorder ❍ Kidney Stones ❍ Prostate Disorders
❍ Other Urinary Tract Disorder(s)

[9] DIGESTIVE TRACT DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #9: "Stomach, intestines, gallbladder…"}*
Select all conditions that apply:
❍ Stomach Disorder ❍ Intestines Disorder ❍ Gallbladder Disorders ❍ Liver Disorder
❍ Pancreas Disorder ❍ Ulcer ❍ Colitis ❍ Crohn's Disease
❍ Cirrhosis ❍ Enteritis ❍ Hepatitis ❍ Pancreatitis

[10] COLON DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #10: "Hernia, hemorrhoids, polyps…"}*
Select all conditions that apply:
❍ Hernia ❍ Hemorrhoids ❍ Polyps ❍ Rectal Disorders

[11] EYE, EAR, NOSE AND THROAT DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #11: "Eye, ear, nose…"}*
Select all conditions that apply:
❍ Eye Disorder ❍ Ear Disorder ❍ Nose Disorder ❍ Throat Disorder

[12]SKIN DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #12: "Skin disorders, burns, lacerations…"}*
Select all conditions that apply:
❍ Burns ❍ Lacerations ❍ Dermatitis ❍ Boils
❍ Chronic Rashes ❍ Melanoma ❍ Other Skin Disorder(s)

[13] MUSKULOSKELETAL DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #13: "Back, spine, arm or leg disorder…"}*
Select all conditions that apply:
❍ Back Disorder ❍ Spine Disorder ❍ Arm Disorder ❍ Leg Disorder

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❍ Arthritis ❍ Gout ❍ Bursitis ❍ Neuritis

[14] COMPLICATIONS OF PREGNANCY *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #14: "Complications of pregnancy and/or Cesarean section"}*
Select all conditions that apply:
❍ Cesarean Section ❍ Other Complications of Pregnancy

[15] BRAIN DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #15: "Brain disorder, epilepsy, fainting…"}*
Select all conditions that apply:
❍ Epilepsy ❍ Fainting Spells ❍ Dizziness ❍ Seizures
❍ Paralysis ❍ Tremors ❍ Palsy ❍ Head Injury
❍ Chronic Headaches ❍ Other Brain Disorder(s)

[16] MENTAL AND NERVOUS DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #16: "Mental or nervous disorder, depression…"}*
Select all conditions that apply:
❍ Mental Disorders ❍ Nervous Disorders ❍ Depression ❍ Anxiety
❍ Alcoholism ❍ Drug Addiction

[17] CONNECTIVE TISSUE DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #17: "Hodgkin's or Non-Hodgkin's Lymphoma…"}*
Select all conditions that apply:
❍ Hodgkin's Lymphoma ❍ Non-Hodgkin's Lymphoma ❍ Cystic Fibrosis ❍ Collagen Disease
❍ Other Connective Tissue Disease(s)

[18] ABNORMAL TEST RESULTS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #18: "Any abnormal results of a cancer test…"}*
Select all conditions that apply:
❍ Abnormal Results from PAP Smear ❍ Abnormal Results from Mammogram
❍ Abnormal Results from CEA (Carcinoembryonic Antigen) ❍ Abnormal Results from PSA (Prostate Specific Antigen)
❍ Abnormal Results from Chest X-Ray ❍ Abnormal Results from Other Test

[19] SYMPTOMS FROM OTHER MEDICAL CONDITIONS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #19: "Abnormal bleeding, swollen or enlarged prostate…"}*
Select all conditions that apply:
❍ Abnormal Bleeding ❍ Swollen or Enlarged Prostate ❍ Night Sweats

[20] MUSCULAR DISORDERS *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #20: "Any neurological disease or disorder…"}*
Select all conditions that apply:
❍ Neurological Disease/Disorder ❍ Numbness of an Extremity ❍ Muscular Disease/Disorder
❍ Loss of Use of a Limb

[21] AIDS / HIV *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #21: "Have you or any Applicant ever been diagnosed or treated…"}*
Select all conditions that apply:
❍ AIDS (Acquired Immune Deficiency Syndrome)
❍ AIDS-Related Complex
❍ Tested Positive for HIV (Human Immunodeficiency Virus) or an AIDS-Related Test]

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{The following section/questions will be asked depending on which condition the Applicant chose in the "CONDITIONS" section above.}

[ADDITIONAL HEALTH INFORMATION [section two]

[Based on previous answers, additional information is required. Please complete the requested information for the indicated Applicant. Note: All of the information you provide is for quoting and application purposes only and will be kept confidential.]

Health Information For: [John Doe]

Condition Detail
HAZARDOUS ACTIVITIES OR SPORTS

Condition: Other Aviation Related Activities *{Only asked if Applicant chose "Other Aviation Activities" to ADDITIONAL HEALTH INFORMATION [section one] question #1}*

1. What is the aviation activity you participate in?	[activity]
2. What type(s) of pilot's license do you currently hold?	[pilot's license type(s)]
3. Are you a student pilot or flying instructor?	❍ Yes ❍ No
{If "Yes"} **[** Provide details:	[details] **]**
4. Describe the type of aircraft you normally pilot and/or navigate:	[description]
5. How many TOTAL hours flown?	[total hours]
6. How many hours flown in the past 12 months?	[hours]
7. Do you have a flight instrument rating?	❍ Yes ❍ No
{If "Yes"} **[** Provide details**:**	[details] **]**

Condition Detail
HAZARDOUS ACTIVITIES OR SPORTS

Condition: Other Sports Activities *{Only asked if Applicant chose "Other Sports Activities" to ADDITIONAL HEALTH INFORMATION [section one] question #1}*

Please provide additional details.	[details]
Date of last participation:	[MM/YYYY]

Condition Detail
HEART OR CARDIOVASCULAR CONDITIONS/DISORDERS *{Only asked if Applicant chose Any Form of Heart Surgery; Coronary Artery Surgery; Heart Related Arteriogram; Disease or Disorder of the Heart; or Disease or Disorder of the Circulatory System in ADDITIONAL HEALTH INFORMATION [section one] question #2}*

Condition: [Any Form of Heart Surgery] [Coronary Artery Surgery] [Heart Related Arteriogram] [Disease or Disorder of the Heart] [Disease or Disorder of the Circulatory System]

1. Do you have or have you had a history of:

❍ Bypass	❍ Uncontrolled Hypertension or Tachycardia	❍ Cardiomegaly (Enlarged Heart)
❍ Blocked Arteries	❍ Valvular Heart Disease	❍ Carotid Artery Disease
❍ Stroke or Peripheral Vascular Disease	❍ Raynaud's Disease	❍ Arteritis
❍ Other	❍ Hemophilia	❍ Arteriovenous (AV) Malformation
❍ Rheumatic Fever with Cardiac Residuals	❍ Congestive Heart Failure	❍ Cardiomyopathy

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your condition?	[diagnosis]
3. Date condition diagnosed or discovered:	[MM/YYYY]
4. Is the condition still present?	❍ Yes ❍ No
Please supply date of last occurrence:	[MM/YYYY]
5. Have you ever been disabled or hospitalized?	❍ Yes ❍ No

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{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

6. Was medication taken or prescribed? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

7. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

8. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

9. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

10. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail
HEART OR CARDIOVASCULAR CONDITIONS/DISORDERS *{Only asked if Applicant chose Hypertension in ADDITIONAL*

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HEALTH INFORMATION [section one] question #3}
Condition: [Hypertension]

1. Is the high blood pressure under control? ❍ Yes ❍ No
[If "Yes", for how long? [length of time] **]**

2. Do you have any history of heart or circulatory problems including stroke, heart attack, or blocked arteries?
❍ Yes ❍ No *{If "Yes"}* **[** Details: [details] **]**

3. Last blood pressure readings and dates (3 if known):
[xxx /xxx] [MM/DD/YY];
[xxx /xxx] [MM/DD/YY];
[xxx /xxx] [MM/DD/YY]

4. Date condition diagnosed or discovered: [MM/YYYY]

5. Is the condition still present? ❍ Yes ❍ No
Please supply date of last occurrence: [MM/YYYY]

6. Have you ever been disabled or hospitalized? ❍ Yes ❍ No
{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

7. Was medication taken or prescribed? ❍ Yes ❍ No
{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

9. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:
Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]

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State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

10. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

11. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

ENDOCRINE DISORDERS *{Only asked if Applicant chose Diabetes; Hypoglycemia; Goiter; Thyroid Disorder; or Obesity in ADDITIONAL HEALTH INFORMATION [section one] question #3}*

Condition: [Diabetes] [Hypoglycemia] [Goiter] [Thyroid Disorder] [Obesity]

1. Do you have or have you had a history of:

❍ Glucose Intolerance ❍ Acromegaly ❍ Myxedema
❍ Hyperglycemia ❍ Addison's Disease ❍ Juvenile Hypothyroidism
❍ Pituitary Tumor ❍ Cushing's Disease or Syndrome ❍ Adrenal Gland Disorder
❍ Other ❍ Cretinism

{The following question is only applicable if the Applicant selects "Other" from the question above.}

2. What is/was the diagnosis of your condition?

❍ Hypothyroidism ❍ Hyperthyroidism ❍ Hypoglycemia ❍ Goiter ❍ Thyroid Nodule
❍ Other Condition

{If "Other Condition"} **[** [details] **]**

Details:

3. Date condition diagnosed or discovered: [MM/YYYY]

4. Is the condition still present? ❍ Yes ❍ No

Please supply date of last occurrence: [MM/YYYY]

5. Have you ever been disabled or hospitalized? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

6. Was medication taken or prescribed? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

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7. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

8. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

9. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

10. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

BLOOD DISORDERS *{Only asked if Applicant chose Spleen Disorder; Anemia; or Other Blood Disorder(s) in ADDITIONAL HEALTH INFORMATION [section one] question #4}*

Condition: [Spleen Disorder] [Anemia] [Other Blood Disorder(s)]

Description: [description]
Hospitalization required? ❍ Yes ❍ No
Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]
Physician or Facility Name: [name]

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Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

GYNECOLOGICAL DISORDERS *{Only asked if Applicant chose Breast Disorder or Reproductive Organ Disorder in ADDITIONAL HEALTH INFORMATION [section one] question #5}*

Condition: [Breast Disorder] [Reproductive Organ Disorder]

1. Do you have or have you had a history of:

❍ Endometriosis ❍ Cancer ❍ Abnormal PAP Smears/Dysplasia ❍ Polycystic Ovarian Disease/Syndrome
❍ HPV (Human Papillomavirus) ❍ Other

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

{The following question is only applicable if the Applicant selects "Abnormal PAP smears/Dysplasia" from the list above.}

3. Please provide additional details for Abnormal PAP smears/Dysplasia:

Class of PAP smear, number of abnormal PAPs and dates.
[details]
Number and date of normal PAP smears (since last abnormal PAP)
[details]

4. Date condition diagnosed or discovered: [MM/YYYY]

5. Is the condition still present? ❍ Yes ❍ No
Please supply date of last occurrence: [MM/YYYY]

6. Have you ever been disabled or hospitalized? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

7. Was medication taken or prescribed? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*

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Physician or Facility Name:	[Harris HEB]
Phone Number:	[123-456-7890]
Address Line 1:	[123 Health Street]
Address Line 2:	
City:	[City]
State and Zip:	[TX] [12345]
Date Seen:	[MM/YYYY]

9. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type:	[type of treatment, surgery or physical therapy]
Treating Physician:	*{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name:	[Harris HEB]
Phone Number:	[123-456-7890]
Address Line 1:	[123 Health Street]
Address Line 2:	
City:	[City]
State and Zip:	[TX] [12345]
Start Date:	[MM/YYYY]
Stop Date:	[MM/YYYY]
Fully Recovered?	❍ Yes ❍ No
Additional Details:	[details]

10. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

11. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

CANCER / TUMOR *{Only asked if Applicant chose Cancer; Cyst; Tumor; or Neoplasm in ADDITIONAL HEALTH INFORMATION [section one] question #6}*

Condition: [Cancer] [Cyst] [Tumor] [Neoplasm]

1. Do you have or have you had a history of:

❍ Cancer or Malignant Melanoma within 5 years
❍ Any Chemotherapy or Radiation within 5 years
❍ Recurrent Occurrences of Cancer
❍ Brain Cancer
❍ Other
❍ Metastasis
❍ Hodgkin's Disease
❍ Lymphoma
❍ Non-Hodgkin's Lymphoma
❍ Leukemia
❍ Bone Cancer
❍ Sarcoma

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

3. Date condition diagnosed or discovered: [MM/YYYY]

4. Is the condition still present? ❍ Yes ❍ No

Please supply date of last occurrence: [MM/YYYY]

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5. Have you ever been disabled or hospitalized? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

6. Was medication taken or prescribed? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

7. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

8. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

9. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

10. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

RESPIRATORY DISORDERS *{Only asked if Applicant chose Asthma; Bronchitis; Lung Disease; Breathing Problems; or Other*

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STATEMENT OF VARIABILITY

Respiratory Disorder(s) in ADDITIONAL HEALTH INFORMATION [section one] question #7}

Condition: [Asthma] [Bronchitis] [Lung Disease] [Breathing Problems] [Other Respiratory Disorder(s)]

1. Do you have or have you had a history of:

❍ Lung Transplant ❍ Cystic Fibrosis ❍ Current Tumor or Neoplasm of the Lung
❍ Asthma ❍ Active Tuberculosis ❍ Sarcoidosis within 5 years
❍ Other

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

{The following question is only applicable if the Applicant selects "Asthma" from the list above.}

3. Please provide additional details for Asthma:

a. Are you currently using oral steroids? ❍ Yes ❍ No
b. Is it mild or seasonal? ❍ Yes ❍ No
c. Are you currently using a steroid inhaler? ❍ Yes ❍ No
d. Have you used a steroid inhaler that is no longer required? ❍ Yes ❍ No

4. Date condition diagnosed or discovered: [MM/YYYY]

5. Is the condition still present? ❍ Yes ❍ No
Please supply date of last occurrence: [MM/YYYY]

6. Have you ever been disabled or hospitalized? ❍ Yes ❍ No
{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

7. Was medication taken or prescribed? ❍ Yes ❍ No
{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

9. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]

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Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

10. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

11. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail
URINARY TRACT DISORDERS *{Only asked if Applicant chose Kidney Disorder; Urinary Bladder Disorder; Kidney Stones; Prostate Disorders; or Other Urinary Tract Disorder(s) in ADDITIONAL HEALTH INFORMATION [section one] question #8}*

Condition: [Kidney Disorder] [Urinary Bladder Disorder] [Kidney Stones] [Prostate Disorders] [Other Urinary Tract Disorder(s)]

1. Do you have or have you had a history of:

❍ Renal Failure ❍ Polycystic Kidney Disease ❍ Dialysis or Kidney Transplant Recipient
❍ Chronic Nephritis or Nephrotic Syndrome ❍ Chronic Glomerulonephritis ❍ Elevated PSA
❍ Other ❍ Kidney Stones ❍ BPH (Benign Prostate Hypertrophy)

{The following question is only applicable if the Applicant selects "Other"; "Kidney Stones"; "Elevated PSA"; or "BPH…" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

{The following question is only applicable if the Applicant selects "Kidney Stone" from the list above.}

3. Please provide additional details for Kidney Stones:
Number of occurrences: [number]
Was (were) stone(s) passed? ❍ Yes ❍ No
Are stones now believed to be present? ❍ Yes ❍ No
Details: [details]

{The following question is only applicable if the Applicant selects "Elevated PSA" from the list above.}

4. Please provide additional details for Elevated PSA:
Most Recent Results: [number]
Date of Result: [MM/YYY]

5. Date condition diagnosed or discovered: [MM/YYYY]

6. Is the condition still present? ❍ Yes ❍ No
Please supply date of last occurrence: [MM/YYYY]

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7. Have you ever been disabled or hospitalized? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

8. Was medication taken or prescribed? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

9. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

10. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

11. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

12. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

DIGESTIVE TRACT DISORDERS *{Only asked if Applicant chose Stomach Disorder; Intestines Disorder; Gallbladder Disorder;*

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Liver Disorder; Pancreas Disorder; Ulcer; Colitis; Crohn's Disease; Enteritis; Hepatitis; or Pancreatitis in ADDITIONAL HEALTH INFORMATION [section one] question #9}

Condition: [Stomach Disorder] [Intestines Disorder] [Gallbladder Disorder] [Liver Disorder] [Pancreas Disorder] [Ulcer] [Colitis] [Crohn's Disease] [Enteritis] [Hepatitis] [Pancreatitis]

1. Do you have or have you had a history of:

❍ Hepatitis other than Acute Type A
❍ Bleeding or Recurrent Ulcer within 5 years
❍ Any Weight Loss Surgery
❍ Liver abscess or enlargement within 1 year
❍ Other
❍ Malabsorption Syndrome
❍ Recurrent Pancreatitis
❍ Unoperated Pancreatic Cyst or Tumor
❍ Ulcerative Colitis Controlled by Oral Steroids
❍ Pan Colitis
❍ Peritontis within 1 year
❍ Megacolon
❍ Any Esophageal Varices

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

3. Date condition diagnosed or discovered: [MM/YYYY]

4. Is the condition still present? ❍ Yes ❍ No
Please supply date of last occurrence: [MM/YYYY]

5. Have you ever been disabled or hospitalized? ❍ Yes ❍ No
{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

6. Was medication taken or prescribed? ❍ Yes ❍ No
{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

7. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

8. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]

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Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

9. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

10. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

COLON DISORDERS *{Only asked if Applicant chose Hernia; Hemorrhoids; Polyps; or Rectal Disorders in ADDITIONAL HEALTH INFORMATION [section one] question #10}*

Condition: [Hernia] [Hemorrhoids] [Polyps] [Rectal Disorders]

Description: [description]
Hospitalization required? ❍ Yes ❍ No
Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]
Physician or Facility Name: [name]
Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

EYE, EAR, NOSE, THROAT DISORDERS *{Only asked if Applicant chose "Eye Disorder"; "Ear Disorder"; "Nose Disorder"; or "Throat Disorder" in ADDITIONAL HEALTH INFORMATION [section one] question #11}*

Condition: [Eye Disorder] [Ear Disorder] [Nose Disorder] [Throat Disorder]

Description: [description]
Hospitalization required? ❍ Yes ❍ No

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STATEMENT OF VARIABILITY

Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]
Physician or Facility Name: [name]
Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

SKIN DISORDERS *{Only asked if Applicant chose "Burns"; "Lacerations"; "Dermatitis"; "Boils"; "Chronic Rashes"; "Melanoma"; or "Other Skin Disorder(s)" in ADDITIONAL HEALTH INFORMATION [section one] question #12}*

Condition: [Burns] [Lacerations] [Dermatitis] [Boils] [Chronic Rashes] [Melanoma] [Other Skin Disorder(s)]

Description: [description]
Hospitalization required? ❍ Yes ❍ No
Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]
Physician or Facility Name: [name]
Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

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STATEMENT OF VARIABILITY

MUSCULOSKELETAL DISORDERS *{Only asked if Applicant chose Back Disorder; Spine Disorder; Arm Disorder; Leg Disorder; Arthritis; Gout; Bursitis; or Neuritis in ADDITIONAL HEALTH INFORMATION [section one] question #13}*

Condition: [Back Disorder] [Spine Disorder] [Arm Disorder] [Leg Disorder] [Arthritis] [Gout] [Bursitis] [Neuritis]

1. Do you have or have you had a history of:

❍ Rheumatoid Arthritis
❍ Systemic Lupus
❍ Scoliosis greater than 30 degrees or with Rods
❍ Muscular Distrophy
❍ AS (Ankylosing Spondylitis
❍ Other
❍ Severe or Disabling Degenerative Joint Disease
❍ Severe or Disabling Disc Disease
❍ Severe or Disabling Osteoporosis
❍ Arthritis requiring gold treatments or Methotrexate
❍ Chronic Pain Syndrome
❍ Paralysis
❍ Neuropathy

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

3. What is the specific area involved? Back: ❍ Upper ❍ Middle ❍ Lower

Other Location: ❍ Right ❍ Left ❍ Other

Details: [details]

4. Date condition diagnosed or discovered: [MM/YYYY]

5. Is the condition still present? ❍ Yes ❍ No

Please supply date of last occurrence: [MM/YYYY]

6. Have you ever been disabled or hospitalized? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

7. Was medication taken or prescribed? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

9. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

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Type:	[type of treatment, surgery or physical therapy]
Treating Physician:	*{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name:	[Harris HEB]
Phone Number:	[123-456-7890]
Address Line 1:	[123 Health Street]
Address Line 2:	
City:	[City]
State and Zip:	[TX] [12345]
Start Date:	[MM/YYYY]
Stop Date:	[MM/YYYY]
Fully Recovered?	❍ Yes ❍ No
Additional Details:	[details]

10. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

11. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

COMPLICATIONS OF PREGNANCY *{Only asked if Applicant chose "Cesarean Section" or "Other Complications of Pregnancy" in ADDITIONAL HEALTH INFORMATION [section one] question #14}*

Condition: [Cesarean Section] [Other Complications of Pregnancy]

Description: [description]
Hospitalization required? ❍ Yes ❍ No
Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician:	[physician's name]
Physician or Facility Name:	[name]
Phone Number:	[123-456-7890]
Address Line 1:	[123 Anywhere St.]
Address Line 2:	[Suite 100]
City:	[My Town]
State:	[TX]
ZIP Code:	[12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

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STATEMENT OF VARIABILITY

BRAIN DISORDERS *{Only asked if Applicant chose Epilepsy; Fainting Spells; Dizziness; Seizures; Paralysis; Tremors; Palsy; Head Injury; Chronic Headaches; or Other Brain Disorder(s) in ADDITIONAL HEALTH INFORMATION [section one] question #15}*

Condition: [Brain Disorder] [Epilepsy] [Fainting Spells] [Dizziness] [Seizures] [Paralysis] [Tremors] [Palsy] [Head Injury] [Chronic Headaches]

1. Do you have or have you had a history of:

❍ Brain Bleed (Cerebral Hemorrhage)	❍ Narcolepsy	❍ Cerebral Palsy
❍ Stroke or Cerebrovascular Attack	❍ Neuropathy	❍ Brain Abscess within 5 years
❍ TIA (Transient Ischemic Attack)	❍ Tourette's Syndrome	❍ Alzheimer's Disease
❍ Pituitary Tumor	❍ Congenital Brain Disorder	❍ Hydrocephalus with Shunt/Stent
❍ Malignant Brain Tumor	❍ Parkinson Disease	❍ Other

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

3. If seizure(s), type of seizure(s) [type of seizure] **Frequency:** [frequency]

4. Date condition diagnosed or discovered: [MM/YYYY]

5. Is the condition still present? ❍ Yes ❍ No
Please supply date of last occurrence: [MM/YYYY]

6. Have you ever been disabled or hospitalized? ❍ Yes ❍ No
{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

7. Was medication taken or prescribed? ❍ Yes ❍ No
{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

8. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

9. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:
Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility [Harris HEB]

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Name:
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

10. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

11. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

MENTAL AND NERVOUS DISORDERS *{Only asked if Applicant chose Mental Disorders; Nervous Disorders; Depression; Anxiety; Alcoholism; or Drug Addiction in ADDITIONAL HEALTH INFORMATION [section one] question #16}*

Condition: [Mental Disorders] [Nervous Disorders] [Depression] [Anxiety] [Alcoholism] [Drug Addiction]

1. Do you have or have you had a history of:

❍ Alzheimer's Disease
❍ Anorexia or Bulimia
❍ Moderate or Severe Anxiety
❍ Autism
❍ Bipolar Disorder
❍ Cerebral Palsy
❍ Chemical Imbalance
❍ Dysthymic Disorder
❍ Manic or Major Depression
❍ Post Traumatic Stress Disorder
❍ Psychosis or Psychotic Disorders
❍ Nervous Breakdown within 5 years
❍ Neuropathy
❍ Schizophrenia
❍ Other

{The following question is only applicable if the Applicant selects "Other" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

3. Date condition diagnosed or discovered: [MM/YYYY]

4. Is the condition still present? ❍ Yes ❍ No
Please supply date of last occurrence: [MM/YYYY]

5. Have you ever been disabled or hospitalized? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

6. Was medication taken or prescribed? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]

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[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

7. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

8. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

9. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

10. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

CONNECTIVE TISSUE DISORDERS *{Only asked if Applicant chose "Collagen Disease" or "Connective Tissue Disorder(s)" in ADDITIONAL HEALTH INFORMATION [section one] question #17}*

Condition: [Collagen Disease] [Connective Tissue Disorder]

Description: [description]
Hospitalization required? ❍ Yes ❍ No
Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

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Treating Physician: [physician's name]
Physician or Facility Name: [name]
Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

ABNORMAL TEST RESULTS *{Only asked if Applicant chose "Abnormal Results from PAP Smear"; "Abnormal Results from Mammogram"; "Abnormal Results from CEA…"; "Abnormal Results from PSA…"; "Abnormal Results from Chest X-Ray"; or "Abnormal Results from Other Test" in ADDITIONAL HEALTH INFORMATION [section one] question #18}*

Condition: [Abnormal Results from PAP Smear] [Abnormal Results from Mammogram] [Abnormal Results from CEA (Carcinoembryonic Antigen)] [Abnormal Results from PSA (Prostate Specific Antigen)] [Abnormal Results from Chest X-Ray] [Abnormal Results from Other Test]

Description: [description]
Hospitalization required? ❍ Yes ❍ No
Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]
Physician or Facility Name: [name]
Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

SYMPTOMS OF OTHER MEDICAL CONDITIONS *{Only asked if Applicant chose "Abnormal Bleeding" or "Night Sweats" to ADDITIONAL HEALTH INFORMATION [section one] question #19}*

Condition: [Abnormal Bleeding] [Night Sweats]

Description: [description]
Hospitalization required? ❍ Yes ❍ No

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STATEMENT OF VARIABILITY

Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]
Physician or Facility Name: [name]
Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

URINARY TRACT DISORDERS *{Only asked if Applicant chose Swollen or Enlarged Prostate in ADDITIONAL HEALTH INFORMATION [section one] question #19}*

Condition: Swollen or Enlarged Prostate

1. Do you have or have you had a history of:

❍ Renal Failure ❍ Polycystic Kidney Disease ❍ Dialysis or Kidney Transplant Recipient
❍ Chronic Nephritis or Nephrotic Syndrome ❍ Chronic Glomerulonephritis ❍ Elevated PSA
❍ Other ❍ Kidney Stones ❍ BPH (Benign Prostate Hypertrophy)

{The following question is only applicable if the Applicant selects "Other"; "Kidney Stones"; "Elevated PSA"; or "BPH…" from the list above.}

2. What is/was the diagnosis of your condition? [diagnosis]

{The following question is only applicable if the Applicant selects "Kidney Stone" from the list above.}

3. Please provide additional details for Kidney Stones:

Number of occurrences: [number]
Was (were) stone(s) passed? ❍ Yes ❍ No
Are stones now believed to be present? ❍ Yes ❍ No
Details: [details]

{The following question is only applicable if the Applicant selects "Elevated PSA" from the list above.}

4. Please provide additional details for Elevated PSA:

Most Recent Results: [number]
Date of Result: [MM/YYY]

5. Date condition diagnosed or discovered: [MM/YYYY]

6. Is the condition still present? ❍ Yes ❍ No
Please supply date of last occurrence: [MM/YYYY]

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STATEMENT OF VARIABILITY

7. Have you ever been disabled or hospitalized? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Disability / Hospitalization	Start Date	Stop Date
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY]
[details]	[MM/DD/YYYY]	[MM/DD/YYYY] **]**

8. Was medication taken or prescribed? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Medication	Dosage/Frequency	Start Date	Stop Date	Dr. advised/aware of stopping
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details]
[medication]	[15mg twice per day]	[MM/YY]	[MM/YY]	[details] **]**

9. Please indicate the physicians or facilities who treated you for the condition(s) (most current first).

Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Date Seen: [MM/YYYY]

10. Is there any type of treatment, surgery or physical therapy scheduled, recommended or completed (besides medication)? ❍ Yes ❍ No *{If "Yes"}* **[** Please provide additional details:

Type: [type of treatment, surgery or physical therapy]
Treating Physician: *{Applicant will have the ability to select from a drop-down list based on previously entered physician info}*
Physician or Facility Name: [Harris HEB]
Phone Number: [123-456-7890]
Address Line 1: [123 Health Street]
Address Line 2:
City: [City]
State and Zip: [TX] [12345]
Start Date: [MM/YYYY]
Stop Date: [MM/YYYY]
Fully Recovered? ❍ Yes ❍ No
Additional Details: [details]

11. Any type of testing performed (i.e. Lab work, MRI, EKG, Echo, Scan)? ❍ Yes ❍ No

{If "Yes"} **[** Please provide additional details:

Type of Test	Date of Test	Results and/or further testing?
[MRI]	[MM/YYYY]	[details]
[EKG]	[MM/YYYY]	[details]
[Lab work]	[MM/YYYY]	[details] **]**

12. Have you made a full recovery? ❍ Yes ❍ No

Condition Detail

MUSCULAR DISORDERS *{Only asked if Applicant chose "Neurological Disease/Disorder"; "Numbness of an Extremity";*

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STATEMENT OF VARIABILITY

"Muscular Disease/Disorder"; or "Loss of Use of a Limb" in ADDITIONAL HEALTH INFORMATION [section one] question #20}

Condition: **[Neurological Disease/Disorder] [Numbness of an Extremity] [Muscular Disease/Disorder] [Loss of Use of a Limb]**

Description: [description]
Hospitalization required? ❍ Yes ❍ No
Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]
Physician or Facility Name: [name]
Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]
[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail

RECENT MEDICAL TREATMENT *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #22: ("WITHIN THE LAST FIVE YEARS, have you…")}*

Description: [description]
Hospitalization required? ❍ Yes ❍ No
Operation required? ❍ Yes ❍ No

Treatment Information

Treatment: [details]
Start Date: [MM/DD/YYYY] **Stop Date:** [MM/DD/YYYY]

Enter the treating physician's information below or select previously entered physician name to populate physician details.

Treating Physician: [physician's name]
Physician or Facility Name: [name]
Phone Number: [123-456-7890]
Address Line 1: [123 Anywhere St.]
Address Line 2: [Suite 100]
City: [My Town]
State: [TX] ZIP Code: [12345]

Prescription Information

MEDICATION	DOSAGE / FREQUENCY	START DATE	STOP DATE
[medication]	[50mg; once per day]	[MM/YYYY]	[MM/YYYY]

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[medication]	[100mg; once per day]	[MM/YYYY]	[MM/YYYY]

Condition Detail
FAMILY HISTORY *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #23: ("Have either of your parents, brothers, or sisters been diagnosed…")}*
Condition: Family Record of Proposed Insured

FAMILY MEMBER	IMPAIRMENT	AGE AT ONSET	AGE AT DEATH
[Father] [Mother] [Brother] [Sister]	[impairment]	[age]	[age] [n/a]

Condition Detail
TRANSPLANT *{Only asked if Applicant chose "Yes" to MEDICAL QUESTION #24 & 25: ("Have you or any Applicant ever received (or been diagnosed…" or " Have you or any Applicant ever consulted with or been treated by…")}*
Condition: Transplant

Please provide additional details.
[details]

Additional Prescription Medications
Are there any additional prescription medications that you or any applicant are currently taking, or have been prescribed which have not yet been filled? ❍ Yes ❍ No

Applicant	Medication	Dosage & Frequency	Condition	Start Date	Stop Date
[John Doe]	[Allegra]	[180 mg; twice per day]	[environmental allergies]	[12/2006]	[N/A]
[Jane Doe]	[Astelin]	[2 sprays; twice per day]	[environmental allergies]	[07/2006]	[N/A]
[Baby Doe]	[Zyrtec]	[1 tsp; once per day]	[environmental allergies]	[08/2006]	[03/2007]]

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PAYMENT INFORMATION

[CREDIT/DEBIT CARD INITIAL PAYMENT]

1st Payment:	[$$$.00]
Credit Card Type:	[❍ VISA ❍ MasterCard]
Name of Cardholder as it appears on the card:	[John Doe]
Relationship of Payor to Primary Applicant:	[self]
[Reason for Payor Being Different than Applicant:	[reason] **]**
Type of Card:	[❍ Credit ❍ Debit]
Account Type:	[Personal]
Credit Card Number:	[5525-XXXX-XXXX-XX54]
Expiration Date:	[01/10]
Cardholder's Billing Address Line 1:	[address]
Cardholder's Billing Address Line 2:	
City:	[city]
State:	[TX]
Zip:	[zip code]
Cardholder's Phone Number:	[phone number]

[EFT INITIAL PAYMENT]

1st Payment:	[$$$.00]
Bank Routing Number:	[xxxxx9485]
Bank Account Number:	[xxxxx0089]
Confirm Bank Routing Number:	[xxxxx9485]
Confirm Bank Account Number:	[xxxxx0089]
Check Number:	[1000]
Account Type:	[Personal]
Name of Financial Institution:	[My Favorite Bank]
Primary Name on Bank Account:	**Title:** [Mr.] **Name:** [John C. Doe]
Relationship of Payor to Primary Applicant:	[❍ Self ❍ Spouse ❍ Guardian ❍ Approved Family Member]
[Reason for Payor Being Different than Applicant:	[reason] **]**
Same mailing address as Primary Applicant?	❍ Yes ❍ No
{If "No"} **[Mailing Address:**	[address]
Apt or Suite Number:	[number]
City:	[My Town]
State:	[TX] **ZIP Code:** [12345] **]**
Driver's License Number of Primary on Bank Account:	[xxxxxx78] **State:** [TX]

NOTICE: PAYMENT AUTHORIZATION

Transaction Authorization: By typing in my driver's license or identification number above, I confirm that I am the owner of the account identified by the MICR numbers entered in the Internet check [above] and authorize this merchant and/or TeleCheck to convert my account information entered above into a paper draft drawn on, or an electronic debit to, my account for the amount of this transaction. [If you choose to use a different form of payment, please click Previous.]

For more information on TeleCheck's process and privacy policy, see *{hyperlink}* Internet Check FAQ and *{hyperlink}* TeleCheck Privacy Policy.

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[ONGOING PAYMENTS]

Ongoing Payments:	[● Checking Account Electronic Fund Transfer (EFT) ❍ Savings Account Electronic Fund Transfer (EFT) ❍ Bill Me]
Payment Mode:	[● Monthly ❍ Quarterly ❍ Annually]
Bank Routing Number:	[xxxxx9485]
Bank Account Number:	[xxxxx0089]
Confirm Bank Routing Number:	[xxxxx9485]
Confirm Bank Account Number:	[xxxxx0089]
Account Type:	[Personal]
Name of Financial Institution:	[My Favorite Bank]
Primary Name on Bank Account:	[John C Doe]
Relationship of Payor to Primary Applicant:	[relationship]
[Reason for Payor Being Different than Applicant:	[reason] **]**

HEALTH APPLICATION TERMS AND CONDITIONS

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the certificate/policy is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

ELECTRONIC SIGNATURE – [John Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

☒ By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [John] MI: [C] Last Name: [Doe] Suffix:

ELECTRONIC SIGNATURE – [Jane Doe]

By checking the box and entering my name below, I am indicating my agreement with the indicated statements and my intent to electronically sign this application.

☒ By clicking on the "submit Application button [below], I agree that the responses I have made in completing this electronic document constitute my application for coverage. I am executing this application while in the state of residence indicated.

Please type your name in the spaces below to electronically sign your application.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [Jane] MI: [A] Last Name: [Doe] Suffix:

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FOR HOME OFFICE USE ONLY

Special Request(s):	[office use only text] *{only agent allowed to fill in text here}*
[Association] Membership:	[NASE Premiere] *{system-generated}*
[Association] Membership Number:	[0123456789] *{system-generated}*
[Association Membership] Paid-to Date:	[09/15/2008] *{system-generated}*
[Association Membership] Effective Date:	[06/15/2008] *{system-generated}*
Lead ID:	[1234-ABC]
Market Type:	[Association Group (I)]

ELECTRONIC SIGNATURE – [Bobby Greatagent]

Producer ID: [123456789]

Do you have any knowledge or reason to believe that the proposed Insured(s) is intending to replace or otherwise reduce in value any existing life insurance or annuities? ❍ Yes ❍ No

By checking the box and entering my name below, I am indicating my agreement with the indicated statement and my intent to electronically sign this application.

☐ I certify that each question on this application was asked by me of the Applicant(s), and I have accurately recorded all answers given by the Applicant(s).

OR

☐ I certify to the best of my knowledge and belief the Applicant(s) has/have personally recorded the answers to each question on this application.

Please type your name in the spaces below to electronically sign your application.

First Name: [Bobby] MI: [B] Last Name: [Greatagent] Suffix:

Please re-type your name in the spaces below to confirm your signature.

First Name: [Bobby] MI: [B] Last Name: [Greatagent] Suffix:

END OF APPLICATION FOR INSURANCE